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Issue Date: 31 October 2003

Case No. 2002-BLA 275
2002-BLA 285

In the Matter of:
GWENDOLYN SUE BURKE, Widow of
CLARENCE BURKE,
Miner,

v.

NATIONAL MINES CORPORATION,
Employer,
and
OLD REPUBLIC INSURANCE COMPANY,
Carrier,
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1]The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On March 28, 2002, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 44, 45).[2] A formal hearing on this matter was conducted on April 16, 2003, in Pikeville, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES

The issues in Clarence Burke's living miner's claim are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3 Whether the Miner is totally disabled;

4. Whether the Miner's disability is due to pneumoconiosis; and

5. Whether the evidence establishes a material change in conditions under § 725.309(c), (d).[3]

(DX 44). The issues of whether the regulations are Constitutional, whether the responsible operator is liable for medical and legal expenses, the unavailability of comparable work, and whether the medical tests meet regulatory standards were raised for appellate purposes. At the hearing, Employer withdrew as contested issues the issues of timeliness, status as a miner, length of employment (Employer stipulated to 29 years of coal mine employment), Gwendolyn Burke's status as a dependent, and Employer stipulated that they were the responsible operator who most recently employed Clarence Burke for one cumulative year. (Tr. 13, 14).

The issue in Gwendolyn Burke's survivor's claim are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner's death was due to pneumoconiosis;

[2]In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr" refers to the official transcript of this proceeding.

[3]Even though it was not listed as a contested issue on DX 44 and Employer did not raise it as a contested issue at the hearing, based on the living miner claims from 1988 and 1991 that were both denied, the present living miner's claim must be adjudicated as a duplicate claim since it was filed more than one year after the previous denial of benefits in 1994.

(DX 45). The issues of whether the regulations are Constitutional, whether the responsible operator is liable for medical and legal expenses, the unavailability of comparable work, and whether the medical tests meet regulatory standards were raised for appellate purposes. At the hearing, Employer withdrew as contested issues the issues of timeliness, status as a miner, length of employment (Employer stipulated to 29 years of coal mine employment), partial disability, Gwendolyn Burke's status as a survivor, and Employer stipulated that they were the responsible operator who most recently employed Clarence Burke for one cumulative year. (Tr. 13).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Clarence Burke ("Miner") was born on October 1, 1932. (DX 1). He completed the third grade. (DX 37). He married Gwendolyn Sue (Turner) Burke ("Claimant") on March 19, 1957. (DX 5). Based on the parties stipulations, I find that Miner had one dependent for the purposes of augmentation. Claimant had been married to Miner for forty-three years at the time of his death. (Tr. 17). Based on the parties' stipulation, I find that Claimant was an eligible survivor of Miner.

Procedural History

Miner filed an initial claim for benefits under the Act on September 14, 1988. (DX 37). Following a formal hearing, Administrative Law Judge W. Ralph Musgrove issued a decision and order – denial of benefits on July 17, 1990, wherein he found that Miner had not established the presence of pneumoconiosis. Miner filed a duplicate claim on November 20, 1991. Administrative Law Judge Daniel Roketenetz presided over a formal hearing and then issued a decision and order – denial of benefits on March 31, 1994. (DX 38). Administrative Law Judge Roketenetz denied Miner's duplicate claim after finding that Miner had not established the presence of pneumoconiosis. Following the denial, Miner submitted additional evidence and Employer submitted additional medical evidence. (DX 38). On December 19, 1995, Employer filed a motion to dismiss with prejudice. The District Director, Office of Workers' Compensation Programs ("OWCP") notified Employer that it would take no action on Employer's motion to dismiss since Miner had not filed a new claim for benefits after Administrative Law Judge Roketenetz's March 31, 1994 denial of benefits. (DX 38).

On June 21, 1999, Miner filed his second duplicate claim for benefits under the Act. (DX 1). On January 19, 2000, the OWCP found that Miner was totally disabled due to pneumoconiosis arising out of coal mine employment. (DX 30). Employer objected to the OWCP's determination of entitlement and requested a formal hearing. (DX 35). Thus, Miner began receiving benefits paid from the Black Lung Disability Trust Fund in February 2000. (DX 36). On March 20, 2000, Miner's claim was transferred to the Office of the Administrative Law

Judges for a formal hearing. (DX 39). However, on November 17, 2000, Claimant filed a claim for survivor's benefits under the Act. (DX 40). In her application, Claimant noted that her husband had died on October 15, 2000. (DX 41). Claimant filed medical evidence on her behalf. On March 30, 2001, the OWCP denied the survivor's claim after finding that Miner's death was not due to pneumoconiosis. Claimant appealed on April 3, 2001, and requested a formal hearing. On July 9, 2001, the OWCP noted that Miner's living miner's claim had been forwarded to the Office of the Administrative Law Judges on March 20, 2000 and stated that the survivor's claim was being forwarded to the Office of the Administrative Law Judges for association with the living miner's file. On July 30, 2001, Administrative Law Judge Rudolf Jansen issued an order denying stay and order remanding the living miner claim for consolidation with the survivor's claim. (DX 41). On September 4, 2001, Daniel Roketenetz issued an order of remand, which remanded the survivor's claim to the OWCP to be consolidated with the living miner's claim which was pending before the OWCP. (DX 41). On January 17, 2002, after considering additional medical evidence, the OWCP affirmed the decision awarding benefits in the living miner's claim and again denied the survivor's claim. After counsel for Claimant submitted a letter to the OWCP requesting a clarification of what he believed to be simultaneous letters dated January 17, 2002 awarding and denying benefits to Claimant, On February 20, 2002, the OWCP informed counsel for Claimant that it had affirmed its award of benefits on the living miner's claim, denied benefits on the survivor's claim, and that it was preparing both claims for a formal hearing. On March 28, 2002, the OWCP forwarded both claims to the Office of the Administrative Law Judges for a formal hearing. (DX 43, 44, 45, 46).

Length of Coal Mine Employment

The parties stipulated that Miner was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties also stipulated that Claimant engaged in twenty-nine years of coal mine employment.

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. National Mines Corporation stipulated that it is the employer with whom Miner spent his last cumulative one year period of coal mine employment and is properly designated as the responsible operator in this case. §§ 725.494, 725.495.

MEDICAL EVIDENCE

The parties submitted a joint stipulation of issues and medical evidence. (JX 1). The parties specifically stipulated to present fifty-five chest x-ray interpretations, thirty-five medical exam, consultative, and pathological reports, sixteen pulmonary function tests, and nine arterial blood gas studies. I accept the parties joint stipulation on medical evidence and incorporate it herein to the extent that it is not inconsistent with medical evidence reviewed herein. Additionally, I incorporate by reference, as if fully rewritten herein, the chest x-ray, pulmonary

function tests, arterial blood gas studies, and medical reports contained in the 1990 decision of Administrative Law Judge Musgrove and the 1994 decision of Administrative Law Judge Roketenetz.

X-RAY REPORTS

Exhibit	Date of X-ray	Date of Reading	Physician/Qualifications	Interpretation
DX 38	9/18/95	9/18/95	Sundaram	1/2
DX 38	9/18/95	9/19/95	Reddy	1/2; emphysema
DX 38	9/26/95	10/12/95	Vuskovich	Negative
DX 7	7/7/99	7/7/99	Wicker, B-reader	Negative
DX 9	7/7/99	7/31/99	Sargent, BCR[1], B-reader[2]	negative
DX 20	7/7/99	10/19/99	Gogineni, BCR, B-reader	Negative
DX 21	11/13/99	11/13/99	Dahhan, B-reader	Negative
DX 29	11/13/99	12/21/99	Gogineni, BCR, B-reader	Negative
DX 29	11/13/99	12/23/99	Baek, BCR, B-reader	0/1

Kenneth Grimes, M.D. interpreted several chest x-rays during September and October of 2000, while Miner was hospitalized, that revealed the presence of COPD and pneumonia, but never diagnosed the presence of coal workers' pneumoconiosis. Similarly, in April 1998, Drs. Ford and Rice interpreted chest x-rays to reveal the presence of COPD.

[4] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[5] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

PULMONARY FUNCTION STUDIES

Exhibit/ Date	Co-op./ Undst./ Tracing	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
DX 38[3] 8/17/95	/ / Yes	62 68”	.85	2.78	27.5	30%	Yes---Invalid
DX 38 9/18/95	/ / Yes	62 68”	.92	2.78		33%	Yes---invalid
DX 38 9/26/95	Good/ Good/ Yes	62 68”	1.08	3.04	___	36%	Yes---invalid
DX 7[4] 7/7/99	Good/ Good/ Yes	67 68"[5]	.56 .55*	1.05 1.20*	12 16*	53% 45%	Yes---invalid Yes---invalid
DX 25[6] 10/28/99	/ / Yes	67 68”	.57	1.40			Yes---invalid
DX 23[7] 11/13/99	Good/ Good/ Yes	67 168 cm	.61	.97		62%	Yes---invalid

*post-bronchodilator values

[6] Ben Branscomb, M.D. opined that this test was not valid because the level of effort and understanding was not included, there was evidence of breath holding, variability on the FVC in excess of allowable limits, the absence of two technically good tracings that confirm each other, and a failure to achieve the initial rapid forced expiration required for a valid test.

[7] N.K. Burki, M.D. opined that this test was invalid due to less than optimal effort, cooperation and comprehension, based on variability of curve shapes indicating suboptimal effort.

[8] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that the miner’s actual height is 68 inches.

[9] Dr. Burki opined that this test is not acceptable due to less than optimal effort, cooperation, and comprehension, based on curve shapes that indicate suboptimal effort. (DX 28).

[10] Dr. Burki opined that this test is not acceptable due to less than optimal effort, cooperation, and comprehension, based on curve shapes that indicate suboptimal effort. (DX 23).

ARTERIAL BLOOD GASES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 38	9/18/95	46.1	71.0	No
DX 7[8]	7/7/99	55.3	58.3	Yes
DX 22[9]	11/13/99	49.6	48.2	Yes
DX 34	11/13/99	58	45.6	Yes

*Results obtained with exercise

Narrative Medical Evidence

Raghu Sundaram, M.D. examined Miner on September 18, 1995 and completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. (DX 38). Dr. Sundaram considered a coal mine employment history of thirty-one years, but he did not document a smoking history. Miner complained of dyspnea on exertion. Dr. Sundaram detected wheeze and rhonchi on physical examination of Miner's lungs. He conducted a chest x-ray and a pulmonary function test ("PFT"). He interpreted the chest x-ray as positive for pneumoconiosis. Dr. Sundaram's cardiopulmonary diagnosis was coal workers' pneumoconiosis due to prolonged exposure to coal dust. He determined that Miner had a pulmonary impairment due to coal dust exposure based on Miner's prolonged exposure to coal dust. Dr. Sundaram found that Miner lacked the respiratory capacity to perform his usual coal mine employment or comparable gainful work in a dust-free environment due to Miner's shortness of breath with limited activity.

Matt Vuskovich, M.D. examined Miner on September 26, 1995 and issued a narrative report on October 12, 1995. (DX 38). He noted that Miner had a thirty-one year history of coal mining. Dr. Vuskovich documented a smoking history that began in Miner's teens and continues to the time of his report in the amount of one pack per day. Miner complained of exertional dyspnea, smothering and cough, and wheezing. Dr. Vuskovich noted that Miner had been prescribed inhalers and bronchodilators to treat bronchitis, emphysema and chronic obstructive pulmonary disease ("COPD"). Breath sounds were distant on physical examination. Dr. Vuskovich conducted a chest x-ray, PFT, and EKG and other blood tests. He interpreted the chest x-ray as negative for pneumoconiosis and diagnosed the presence of chronic obstructive emphysema. He found the PFT to reveal a severe obstructive impairment. Dr. Vuskovich diagnosed COPD, emphysema, and severe obstructive impairment secondary to emphysema. He commented that the hallmark of pulmonary disease caused by cigarette smoking is obstructive impairment. He discussed the disease processes of COPD and chronic bronchitis in depth, with citations to medical literature. Dr. Vuskovich stated that coal workers' pneumoconiosis

11 Dr. Burki found this test to be technically acceptable.
12 Dr. Burki found this test to be technically acceptable. (DX 22).

("CWP") causes a restrictive impairment, and only when it is the highest categories and when there is progressive massive fibrosis. He also discussed the differences between obstructive and restrictive disease. Dr. Vuskovich concluded that there is no objective evidence to make a diagnosis of CWP. He found no occupational pulmonary disease. Dr. Vuskovich reiterated that Miner's severe obstructive impairment is secondary to emphysema that was caused by cigarette smoking. From a pulmonary standpoint, Dr. Vuskovich found that Miner could not return to his previous coal mining position.

Raghu Sundaram, M.D. examined Miner on April 6, 1998, with Miner complaining of a spot on his lung, cough, and shortness of breath. Dr. Sundaram noted that Miner had a bronchoscopy without any tissue diagnosis. He noted that Miner was a retired coal miner who had smoked heavily and then stopped in 1996. Dr. Sundaram noted that a chest x-ray shows moderately advanced emphysema and a lobulated mass in the right front hilum, which is highly suspicious for a neoplasm. Dr. Sundaram's final impression was probably neoplasm, and he recommended a bronchoscopy, thoracotomy, and resection for definite tissue diagnosis and treatment.

Mitchell Wicker, M.D. examined Miner on July 7, 1999 and completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. (DX 7). He read the Employment History form completed by Miner and considered a smoking history of one pack of cigarettes from age seven or eight until age sixty-four. Miner complained of occasional wheezing, constant dyspnea, and a cough. Dr. Wicker detected diminished breath sounds upon auscultation. He noted that Miner constantly uses supplemental oxygen. Dr. Wicker conducted a chest x-ray, PFT, arterial blood gas study ("ABG"), and an EKG. He stated that he saw no evidence of pneumoconiosis. Dr. Wicker opined that Miner's respiratory capacity does not appear to be adequate to perform his previous occupation in the coal mining industry. He attributed Miner's pulmonary impairment to Miner's history of cigarette abuse and his known partial resection.

On September 20, 1999, in response to a Department of Labor letter requesting Miner to undergo another PFT, since Dr. Burki found the previous PFT to be invalid, Dr. Sundaram wrote on a prescription pad that Miner is unable to perform a PFT due to his disabling breathing impairment with a history of bronchogenia, carcinoma, and end stage COPD, CWP.

Abdul Dahhan, who is board-certified in internal medicine and the subspecialty of internal disease, examined Miner on November 13, 1999 and issued a narrative report on November 16, 1999. (DX 21). Dr. Dahhan considered a coal mine employment history of thirty-one years and a smoking history of forty-six pack years. Miner complained of frequent wheeze and dyspnea on exertion of a few feet. Dr. Dahhan noted that Miner constantly uses supplemental oxygen, as well as an inhaler and nebulizer. He also noted that Miner had a brain abscess drained fifteen years ago, in addition to resection of cancer from the right lung two years ago followed by chemotherapy and twenty-one radiation therapy sessions. Dr. Dahhan detected reduced air entry into Miner's lungs with bilateral expiratory wheeze. He conducted a chest x-ray, PFT, ABG, and a EKG. Dr. Dahhan found the x-ray to show hyperinflated lungs consistent with emphysema. He interpreted the PFT as showing an FVC of 24% of predicted, and FEV1 of 19% of predicted. He did not conduct a PFT because of Miner's overall poor condition. He

found the ABG to indicate severe hypoxemia. The EKG showed sinus tachycardia. Based on the occupational, clinical, radiological and physiological evaluation of Miner, Dr. Dahhan opined that Miner has no evidence of occupational pneumoconiosis or pulmonary disability secondary to coal dust exposure as demonstrated by obstructive abnormalities on clinical examination of the chest, obstructive abnormalities on the PFT, and clear chest x-ray. Dr. Dahhan concluded that Miner had emphysema that resulted from Miner's forty-six pack years of smoking and cancer of the right upper lobe post resection with chemo and radiation therapy with secondary pulmonary disability.

Dr. Sundaram examined Miner October 28, 1999 and completed a Department of Labor Medical History and Examination for Coal Workers' Pneumoconiosis form. He did not document the length of Miner's coal mine employment history, and he considered a smoking history in the amount of one pack per day ending in 1996. Miner complained of sputum, wheezing, chest pain and dyspnea upon walking one block, and a cough. Upon auscultation Dr. Sundaram detected bilateral rhonchi and wheeze. He conducted a PFT. Dr. Sundaram diagnosed CWP based on a prolonged history of coal dust exposure. He determined that Miner had a class four pulmonary impairment, which was one-hundred percent attributable to CWP. On an attached form, Dr. Sundaram found that Miner was totally disabled. He then wrote "yes" and drew a line to the word "pneumoconiosis," and then he wrote "stopped smoking several years ago" and drew an arrow to the word "another." Dr. Sundaram wrote this under the question of whether Miner's pulmonary impairment was related to pneumoconiosis or if it had another etiology. Dr. Sundaram stated that Miner did not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment due to shortness of breath with limited activity.

Dr. Dahhan was deposed on March 13, 2000. He reiterated the findings and conclusions contained in his November 1, 1999 exam report.

Dr. Sundaram was deposed on March 18, 2000. Dr. Sundaram testified that he had been treating Miner for several years, dating back to June 22, 1989. (DX 43). He reiterated the findings and conclusions found in his October 29, 1999 report. Dr. Sundaram could not recall or locate in his file any chest x-ray that he interpreted in conjunction with the October 29, 1999 examination and report. Dr. Sundaram noted that there was a greater than 5% variability in the FEV1 value from the PFT he performed on October 29, 1999, but he did not classify it as an invalid study. Dr. Sundaram stated that it was not a consistent finding, but noted that Miner was too weak to do the test because of his severe shortness of breath. Dr. Sundaram stated that smoking played some role in Miner's pulmonary impairment, but since Miner stopped smoking there could be some reversibility of the damage and it is generally difficult to differentiate between smoking and coal dust exposure as an etiology. Dr. Sundaram noted that it was very difficult for Miner to submit to a PFT, but Dr. Sundaram had recommended that Miner submit to the PFT on October 29, 1999 just to try it so that Miner could show that he was not trying to evade taking a PFT and because Miner's symptoms would wax and wane.

Dr. Dahhan submitted a consultative opinion on June 30, 2000 after reviewing and summarizing Miner's medical records developed before and after his November 16, 1999 report. (DX 43). After his summary of the medical evidence, Dr. Dahhan stated that "[i]n conclusion,

based on my examination of [Miner] in the past as well as my review of his medical records as described above, within a reasonable degree of medical certainty, the following conclusions can be made:" 1). Miner did not suffer from CWP or pulmonary disability when he was examined after his termination of coal dust exposure in 1988; 2). Miner did have a mild obstructive ventilatory defect, which was not disabling in nature in 1988; 3). Miner is presently disabled due to cancer of the right upper lobe refractory to surgery, radiation and chemotherapy and also by his COPD with emphysema; 4). Miner's lung cancer is a condition that is not caused or related to his coal dust exposure; 5). Miner's pulmonary disability is contributed to by his emphysema, which resulted from Miner's lengthy smoking habit; and 6). Miner's emphysema and secondary severe obstructive airways disease was not caused by coal dust exposure. Dr. Dahhan opined that the record indicates that Miner's emphysema and secondary severe obstructive airways disease was not present in 1988, which was as few months after Miner ended his exposure to coal dust. He commented that the type of emphysema that Miner had is severe and disabling in nature and is not seen secondary to coal dust induced obstructive airway disease. Furthermore, Dr. Dahhan opined that Miner's emphysema demonstrated response to bronchodilator therapy, which is another finding that is inconsistent with the permanent adverse affects of coal dust on the respiratory system.

Ben Branscomb, M.D., who is board-certified in internal medicine, issued a consultative opinion on July 3, 2000 after he reviewed and summarized additional medical records that he did not review in his prior opinion. (DX 43). He noted that the newly reviewed records show a coal dust exposure history of thirty-one years. Dr. Branscomb documented the accounts of Miner's smoking history contained in the new records and opined that they reinforce the devastating exposure to tobacco over most of Miner's life. Based on Dr. Sundaram's diagnosis of asthma dating back to childhood, Dr. Branscomb noted that the presence of asthma greatly magnifies the likelihood that cigarette smoking will result in chronic asthmatic bronchitis, COPD, or emphysema. Dr. Branscomb commented that the tissue removed during the partial resection of Miner's right lung and hilar lymph nodes in 1998, based on Dr. Bensema's pathological report, does not demonstrate the presence of pneumoconiosis because Dr. Bensema did not describe the pathologic findings of any pneumoconiosis because there were no findings of a specific scarring reaction to that dust. However, Dr. Branscomb then noted that Dr. Bensema used the word "anthracosilicosis" in his diagnoses, stating that "anthracosilicosis" is a term that is no longer generally used, but it can mean the presence of carbon and silica particles in the lung, or its definition can include the scarring process of CWP or silicosis. Dr. Branscomb agreed with Dr. Sundaram's deposition testimony that Miner's pulmonary symptoms waxed and waned, which he considered to be consistent with asthma or asthmatic bronchitis, and which he considered to not be consistent with CWP. Dr. Branscomb opined that the non-occupational nature of Miner's pulmonary disease and impairment is ultimately confirmed by marked progression since his retirement from mining, the intermittent character of the manifestations, the response to bronchodilators seen by some and used as a basis for his treatment, the prolonged duration of smoking, the presence of a complete clinical pattern unknown in early or x-ray negative CWP, as well as other findings. Dr. Branscomb opined that his review of the x-rays reveals that they do not support a finding of CWP. He did find that the x-rays show hyperinflation or emphysema, which supports the fact that Miner's pulmonary impairment is obstructive and not restrictive. Dr. Branscomb noted that he could not locate any valid PFT in the record. He opined that the test curves show many examples of patterns which are the result of a patient withholding

maximum effort. After reviewing the ABGs, Dr. Branscomb stated that he has no doubt that Miner has been totally disabled from coal mining since July 7, 1999, and that he was probably able to perform coal mining as late as December 10, 1993. He noted that Miner's pulmonary symptoms and impairment progressed a great deal after 1993. Dr. Branscomb stated that the new records confirm his prior opinions that there is no evidence of pneumoconiosis or any other occupational pulmonary disease, and that there is no pulmonary impairment either caused or aggravated by coal dust exposure or pneumoconiosis. He concluded that Miner has been totally disabled from coal mining since July 1999 due to the combination of severe chronic asthmatic bronchitis, lung resection, and perhaps an additional component of radiation injury. Dr. Branscomb stated that all of Miner's pulmonary diseases are diseases of the general public that are neither caused by nor influenced by coal dust exposure or CWP. Even assuming the presence of a simple pneumoconiosis, Dr. Branscomb would still conclude that Miner's pulmonary impairment was solely due to cigarette smoking plus other non-occupational factors and was to no significant degree aggravated or caused by simple CWP.

Gregory Fino, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, issued a thirty-eight page consultative opinion on July 19, 2000 after reviewing and summarizing Miner's medical records. (DX 43). He considered a coal mine employment history of thirty-two years as a roof-bolter. Dr. Fino also documented the conflicting accounts of smoking history reported by Miner. Dr. Fino opined that Miner does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure based on: 1). A majority of the chest x-rays are negative for pneumoconiosis; 2). The spirometric studies show an obstructive ventilatory defect that has occurred in the absence of an interstitial abnormality. The defect involves the small airways, which is not consistent with a coal dust related condition, but is consistent with cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma; 3). Improvement in lung function following the use of a bronchodilator that implies that the cause of the obstruction is not fixed and permanent; 4). The lung biopsy showed evidence of coal mine dust deposition in the lungs called anthracosis, but it did not show CWP because there was no description of coal macules surrounded by fibrosis and emphysema; and 5). Miner does have a severe obstructive abnormality that has worsened over the years, after he stopped mining but continued smoking, which is consistent with a smoking related disease. Dr. Fino noted that Miner's pulmonary system is abnormal, and that he does not retain the respiratory capacity to perform all of the requirements of his last job. However, Dr. Fino concluded that the clinical evidence shows that of the two risk factors that could have caused Miner's pulmonary disability, smoking and coal dust exposure, smoking is the factor that caused Miner's disability. Dr. Fino also stated, that even assuming industrial bronchitis due to coal mine employment contributed to Miner's disability, Miner would still be totally disabled if the small level of disability was repaired. Dr. Fino then provided a lengthy discussion on the medical ability to differentiate between the etiologies of pulmonary disease and impairment.

Tamara Musgrave, M.D. provided a report dated July 12, 2000. (DX 43). On the form that Dr. Musgrave completed, she marked the "Yes" box under the question of whether Miner suffered from an occupational lung disease caused by coal mine employment. Dr. Musgrave based that opinion on a chest x-ray and PFT. She marked that Miner was totally disabled due to a pulmonary impairment. She attributed the etiology of Miner's impairment to pneumoconiosis

because Miner's "lung cancer is in remission and no evidence of disease." Dr. Musgrave concluded that Miner does not retain the respiratory capacity to perform his usual coal mine employment or comparable work in a dust-free environment because Miner is "respiratory cripple and can move only limited amount with SOB – totally dependent on O_2 his – his frequent hospitalization – frequently on ventilatory for poor lung capacity."

Dr. Fino was deposed on November 9, 2000. (DX 43). He reiterated the finding and conclusions contained in his July 19, 2000 report.

On December 7, 2000, Dr. Sundaram submitted a brief letter, in which he stated he had reviewed the autopsy report. He noted that the report indicated "anthracic [sic] pigment distributed in the fibrous tissue bilaterally associated with the work history of 31 years exposure to coal dust." Dr. Sundaram opined that this "does confirm and support substantial evidence for coal workers' pneumoconiosis with a reasoned medical opinion."

On May 29, 2001, Dr. Fino issued a supplemental consultative opinion after reviewing additional medical records that he had not reviewed before rendering his July 19, 2000 opinion. (DX 43). Dr. Fino prepared a lengthy flow chart documenting all of the objective medical evidence he reviewed, as well as Miner's occupational and smoking histories. Dr. Fino concluded that he found no evidence of CWP based on his review of all of the information, his old reviews, and the lack of pneumoconiosis at the autopsy. He opined that Claimant's death was a cardiopulmonary arrest due to severe cachexia, or wasting away. Dr. Fino attributed the cachexia to Miner's lung cancer. He opined that, based on his review of all the information, Miner would have died as and when he did had never stepped foot in the mines; Miner's death was unrelated to coal mine dust inhalation.

On June 7, 2001, Dr. Sundaram completed an examination form. He answered "Yes" to the question of whether Miner had a chronic pulmonary impairment and/or black lung that was caused by his twenty-nine years of coal mine employment. (DX 43). Dr. Sundaram listed small cell carcinoma as a possible etiology of Miner's impairment, but noted that he developed it only at a very late point in life. Dr. Sundaram also answered "Yes" to the question of whether Miner's lung condition caused, contributed to, or hastened Miner's death, referring the reader to enclosed medical records for support. The enclosed medical records included Dr. Bensema's 1998 biopsy report, the autopsy, and his own treatment records.

Dr. Sundaram was deposed again on July 30, 2001. He reiterated the findings and conclusions contained in his June 7, 2001 opinion. (DX 43). His June 7, 2001 report was based on x-ray interpretations he had on file dating back to 1988, clinical examinations, and the autopsy report. Dr. Sundaram testified that the fact that Miner's compromised lung status from the silicosis was detrimental on top of Miner's cancer formed the basis for his June 7, 2001 opinion that Miner's death was caused, contributed to, or hastened by his lung condition. Again, Dr. Sundaram could not recall an accurate account of Miner's smoking and coal mine employment history. He was only able to note that Miner's had quit smoking quite many years ago and worked several years as a coal miner. Referring to the autopsy report, Dr. Sundaram stated that fibrous plaque and anthracosis indicates the presence of pneumoconiosis. Dr. Sundaram noted that macules were not present, but he added that their presence was not required

to diagnose pneumoconiosis; macules represent an advanced stage of pneumoconiosis. Dr. Sundaram reported being Miner's treating physician since 1995. He prescribed antibiotics and bronchodilators for Miner as needed.

On September 6, 2001, Dr. Dahhan issued a supplemental consultative report after reviewing additional medical reports, including the pathology report from the 1998 biopsy, hospital records from 1999 and 2000, and consultative reports from other physicians. (DX 43). After summarizing the records he reviewed, Dr. Dahhan opined that: 1). There is insufficient objective data to justify the diagnosis of CWP since the gold standard for making the diagnosis, i.e. pathological tissue from the lung, did not reveal the presence of pneumoconiosis according to Dr. Hansbarger and Dr. Bensema; 2). Miner was totally disabled prior to his death because of his lung cancer and its complications; and 3). Miner did have centrilobular emphysema, which was caused by many years of smoking with no evidence that it was caused by, contributed to, or aggravated by the inhalation of coal dust or CWP.

Dr. Musgrave offered a brief narrative report on October 1, 2001. (DX 43, CX 2[10]). She noted that she had treated Miner from April 30, 1998 to his death. Dr. Musgrave stated that Miner's small cell lung cancer was in remission at the time of his death, with no evidence of the disease at the time of his death. She stated that Miner also had colon cancer, for which he was receiving adjuvant therapy. Dr. Musgrave opined that Miner died from problems related to his chronic black lung disease with respiratory insufficiency.

On June 18, 2002, Dr. Sundaram completed a treating physician form. (CX 1). He answered "Yes" to the question of whether Miner suffered from an occupational lung disease based on Miner's prolonged exposure to coal dust. When asked if he diagnosed the presence of pneumoconiosis solely on x-ray evidence or also based upon his treatment of Miner over a period of years, Dr. Sundaram wrote "yes" and drew an arrow to the word treatment, which I infer is an indication that he based his diagnosis of pneumoconiosis on chest x-ray evidence and his treatment of Miner over a period of time. Under the question of "[f]or each respiratory condition diagnosed, please state whether the condition was significantly contributed to, or substantially aggravated by, dust exposure in coal mine employment," Dr. Sundaram wrote "COPD & exacerbation" and he wrote "yes" twice attached to arrows pointing to the words "aggravated" and "significantly." Dr. Sundaram then wrote "yes" attached to an arrow pointing to the word "whole" in the question that asked if Miner's chronic lung disease was a condition causally related, in whole or in part, to the inhalation of coal mine dust. He answered that it was difficult to separate the impairment from coal dust versus cigarette smoking. He answered "Yes" to the question of whether he believes that pneumoconiosis contributed to or played a hastening role in Miner's death, with the stated rationale of "please see enclosed." Dr. Sundaram stated that he prescribed Miner with home oxygen because Miner had low oxygen levels. He noted that he treated Miner from 1989 until Miner's death. There were no other documents attached to Dr. Sundaram's June 18, 2002 report as submitted by Claimant.

[13] Counsel for Complainant asserted in the cover letter dated March 27, 2003, which was labeled as CX 2, that Claimant was submitting the October 1, 2001 report of Dr. Musgrave and an MRI from Central Baptist Hospital performed on April 16, 1998. Dr. Musgrave's report was attached as referenced, however, there was no MRI report from April 16, 1998 attached, only the first page of the surgical pathology report prepared by Dr. Bensema.

Bruce Broudy, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary disease, issued a consultative report on March 10, 2003. (EX 3). He reviewed and summarized Miner's medical records, including consultative reports, pathology reports, and his previous opinions from 1989 and 1993. Dr. Broudy stated that he believes the evidence suggests that Miner had microscopic evidence of minimal simple CWP, which was not clinically apparent prior to Miner's death and had no affect on Miner's pulmonary function or ultimate medical outcome. Dr. Broudy attributed Miner's death to complications of small cell cancer, which is considered all but incurable. Dr. Broudy noted that the evidence indicates that Miner did not retain the respiratory capacity to perform the work of an underground coal miner or similarly arduous manual labor due to COPD arising out of cigarette smoking. He found no evidence of any pulmonary impairment arising out of Miner's occupation as a coal miner. Dr. Broudy opined that there is no evidence that Miner's death was caused or hastened by inhalation of coal mine dust.

Also on March 10, 2003, Dr. Dahhan issued another supplemental, consultative report. (DX 5). He reviewed and summarized additional medical records. Dr. Dahhan concluded that Miner suffered from very minimal simple CWP according to the majority of the pathologists who examined Miner's lung tissue. He stated that the amount of CWP found on tissue examination according to the majority of the pathologists was too minimal to cause any respiratory impairment or contribute to Miner's death. Dr. Dahhan opined that the data does not indicate the presence of complicated pneumoconiosis or progressive massive fibrosis. He stated that Miner died as a result of small cell lung cancer and its complications, noting that it is well-documented that one-year survival after a patient is diagnosed with small cell lung cancer is extremely low. Dr. Dahhan concluded that Miner's death was not caused by, related to, contributed to, or aggravated by his minimum simple CWP, nor did Miner's simple CWP hasten his final outcome.

Dr. Fino issued another consultative, supplemental report on March 13, 2003 that was eleven lines in length. (EX 4). He noted that he reviewed the pathology reports of Dr. Perper and Caffrey and the surgical pathology report from April 18, 1998. Dr. Fino's analysis, under the heading of conclusion, simply stated, "I agree with the opinions of Dr. Perper and Dr. Caffrey: Simple coal workers' pneumoconiosis did not cause, contribute to or hasten [Miner's] death."

Dr. Broudy was deposed on March 25, 2003. (EX 7). He reiterated the findings and conclusions contained in his March 10, 2003 report.

Dr. Dahhan was deposed again on April 11, 2003. (EX 6). He reiterated the findings and conclusions contained in his March 10, 2003 report.

Pathology Records

Marian Bensema, M.D. issued a pathology report on April 16, 1998 from a biopsy of Miner's hilar mass and the right upper lobe, wedge resection performed on April 16, 1998 by Dr. Saha. (DX 43). Dr. Bensema diagnosed small cell undifferentiated carcinoma from the hilar mass samples, and fibrous plaque with anthracosis and refractile material compatible with

silicates. Dr. Bensema provided a gross and microscopic description of the tissue. Regarding the tissue sample obtained from Miner's right upper lobe, Dr. Bensema provided the following microscopic findings: "[t]he second biopsy shows a dense fibrous plaque with brown granular pigment and some chronic inflammation. No granulomatous change or tumor is seen within this. With polarized light, refractile material compatible with silicate are also seen within this plaque. The surrounding lung shows some emphysematous changes."

Echols Hansbarger, M.D., who is board-certified in clinical and anatomical pathology, issued a consultative report on August 21, 2000 after reviewing some of Miner's medical records, the surgical pathology report from 1998, and three slides containing tissue samples from the 1998 biopsy. Dr. Hansbarger stated that he agreed with the surgical pathology report of Dr. Bensema. He noted that he found no evidence of occupational pneumoconiosis of any variety, especially CWP, in the material available for study. Dr. Hansbarger commented that the undifferentiated carcinoma of the lung and bullous centrilobular emphysema of the lung, which are noted in the lung sections of Miner, are as a direct result of his long pack year history of cigarette smoking and are not related in any way to Miner's coal mine employment history. He voiced his agreement with the reports of numerous consultants who state that occupational pneumoconiosis is not present. On a separate page entitled review of pathology, Dr. Hansbarger provided a microscopic description of the slides. He noted that sections reveal lung with severe diffuse bullous centrilobular emphysema with enlarged airspaces and clubbed septa. Scattered throughout the lung parenchyma he detected focal deposits of anthracotic pigment without reactive fibrosis. Dr. Hansbarger did not identify coal maculae. Dr. Hansbarger's diagnosis was: 1). Undifferentiated carcinoma; 2). Bullous centrilobular emphysema; 3). Healed subpleural granuloma; and 4). Anthracotic pigmentation, mild, focal, of right lung.

Dr. Hansbarger was deposed on September 20, 2000. He reiterated the findings and conclusions contained in his August 21, 2000 pathology report. Dr. Hansbarger testified that undifferentiated carcinoma is not the result of inhalation of coal dust, rather, it is practically always a direct result of long-pack year history of cigarette smoking. Similarly, Dr. Hansbarger attributed Miner's bullous centrilobular emphysema to cigarette smoking.

George Bean, M.D. performed an autopsy confined to Miner's lungs on November 16, 2000. He provided a gross and microscopic description. Under his microscopic description, Dr. Bean stated that no macules were seen. Dr. Bean diagnosed: 1). Emphysema, predominantly panacinar; 2). Consolidating pneumonia with necrosis – left upper lobe; 3). Foreign body reaction suggestive of aspiration pneumonia – right upper lobe; 4). Extensive pleural adhesions; 5). Anthracosis; 6). Bilateral pleural effusions; and 7). No evidence of coal workers' pneumoconiosis is seen.

Joshua Perper, M.D., who is board-certified in anatomical, surgical, and forensic pathology, issued consultative report on February 19, 2001. (DX 41). He reviewed and provided a lengthy and exhaustive summary of Miner's medical records, including thirteen autopsy slides, the autopsy report, hospital records, objective tests, and examination and consultative reports of other physicians. Regarding the autopsy slides, Dr. Perper stated that he received thirteen autopsy slides, which were numbered from "1 through 12." He noted that slide number seven was broken in transit into two fragments, with one containing the label and the

other containing the lung section. Dr. Perper set forth microscopic findings and observations. He rendered the following microscopic diagnoses: 1). Acute and organizing bronchopneumonia with focal evidence of aspiration pneumonia; 2). Severe pulmonary emphysema, mainly pan-acinar; and 3). CWP minimal, with focal micro-nodules and no evidence of silica crystals. Dr. Perper then provided thee answers to "Medicolegal Questions." First, he stated that the autopsy finding of Miner's lungs showed minimal evidence of simple CWP, with a tiny aggregate of micro-nodules in one lung slide out of a total of twelve slides, in spite of adequate sampling of lung sections and adequate histological staining. He noted that there was no evidence of birefringent silica crystals. He stated that the finding is so minimal that it is not surprising that the autopsy prosector did not diagnose CWP. However, Dr. Perper stated it was surprising that that there was only minimal amounts of anthracosis, pneumonconiotic micro-nodules and the absence of silica crystals in a miner with a long standing exposure to coal dust that could be expected to have much more significant pneumoconiosis. At the time of Miner's death, Dr. Perper stated that the answer is clearly negative that Miner was not totally disabled due to a respiratory impairment arising out of coal mine employment, because Miner's CWP was so minimal and sparse that it could not have resulted in pulmonary disability. He found that Miner was disabled due to pulmonary disease in the form of chronic COPD, pulmonary emphysema and status post resection of lung cancer, all resulting from Miner's continuous thirty-five to forty-five years of heavy smoking. Dr. Perper noted that significant CWP and silicosis have been associated with the development of centrilobular emphysema and more controversially with lung cancer, however, Miner had less than an insignificant degree of pneumoconiosis and no silicosis. Thus, Dr. Perper found cigarette smoking to be the exclusive cause of Miner's pulmonary disability. Dr. Perper also stated that Miner's death was not significantly contributed or hastened by pneumoconiosis. He found that Miner's respiratory conditions and related complications, which contributed to Miner's death, were all secondary to his heavy smoking. Dr. Perper then provided five conclusions based on his review of all of the records, which essentially mirror his answers to the "Medicolegal Questions." He did opine that Miner's death was caused by severe chronic lung disease and related complications, which were non-occupational in nature and were all a result of Miner's long standing and heavy smoking of tobacco.

On June 18, 2001, Carlos DeLara, M.D. issued a consultative review after examining twelve slides of Miner's lungs obtained from Miner's autopsy. Dr. DeLara commented that sections show "severe emphysema of both lungs with focal interstitial fibrosis." He detected areas of severe organizing pneumonia and evidence of aspiration pneumonia in the left and right lungs respectively. Dr. DeLara also detected diffuse deposits of coal dusts in all section, some within histocytes and present around alveoli, bronchioles, and blood vessels. He noted the presence of mild reactive fibrosis in some areas, especially in the subpleural with macule formation. Dr. DeLara's diagnosis was: 1). Simple CWP; 2). Acute organizing bronchopneumonia; 3). Pulmonary emphysema and fibrosis; and 5). Aspiration pneumonia. Dr. DeLara commented that Miner was a sixty-eight year old man who worked in or around the coal mines for thirty-one years, and whose lungs showed on autopsy simple CWP. Dr. DeLara stated that the immediate cause of death was due to severe organizing bronchopneumonia and also aspiration pneumonia.

Richard Naeye, M.D., who is board-certified in clinical and anatomical pathology, issued a consultative report on September 11, 2002. (EX 1). Dr. Naeye reviewed and summarized hospital records, Miner's death certificate, consultative reports, the autopsy report, and the slides from the autopsy. Dr. Naeye considered a coal mine employment history of thirty-one years and a smoking history of one-to-three packs per day for twenty-five to forty-five years. Upon reviewing ten autopsy slides, Dr. Naeye microscopically observed that there is no more black pigment in the lung tissues than is present in the lungs of some non-miners at the time they died. He stated that the pigment is in the form of rare, very tiny black deposits at sites beneath the pleura and adjacent to small arteries and airways. Dr. Naeye noted that there is no pigment associated with fibrosis, focal or centrilobular emphysema, which are the minimum findings required to diagnose CWP pathologically. He identified two other dominating disorders in the lung tissue, which are severe centrilobular emphysema and a widespread, necrotizing acute lobular pneumonia that has reached the abscess stage at many sites. Dr. Naeye allowed that there are two sites in the lung tissue available for review where tissue findings might be the consequence of occupational exposure to mine dust. He stated that these two areas contain partially hyanized fibrosis , but no tiny birefringent crystals of free silica and only very rare larger crystals of non-toxic silicates associated with the fibrosis. Dr. Naeye cited to medical literature regarding the pathological diagnosis of CWP, which requires that tissue damage be associated with black pigment at subpleural sites and sites adjacent to small pulmonary arteries and airways. He concluded that nowhere in Miner's lung tissue is there anthracotic pigment specifically associated with fibrosis, focal or centrilobular emphysema. In the rare sites where some fibrosis is present, black pigment is rare and the toxic, tiny crystals of free silica absent. Thus, Dr. Naeye concluded that the minimum findings for the diagnosis of simple CWP are absent. He finds no basis for postulating that CWP caused Miner's disability, prevented him from mining coal, or even had a miner role in hastening his death. Dr. Naeye also referenced medical literature to support his statement that there is no relationship between lung cancer and coal mining.

P. Raphael Caffrey, M.D., who is board-certified in clinical and anatomical pathology, issued a consultative report on February 6, 2003. (EX 2). He reviewed Miner's medical records, including consultative reports, Miner's death certificate, the autopsy report, and twelve autopsy slides. Dr. Caffrey set forth his observations from a microscopic examination of the autopsy slides. He detected panlobular emphysema in the slides from Miner's right lung, but mainly also centrilobular emphysema of a moderately severe degree. He detected focal acute pneumonia of aspiration type with giant cells. On slide number two from Miner's right lung, Dr. Caffrey detected four one millimeter micro-nodules subpleurally with only a slight amount of anthracotic pigment. Under a polarized light, no birefringent particles of silica were seen. On all slides from Miner's right lung, only a small amount of anthracotic pigment was seen. From the slides of Miner's left lung, Dr. Caffrey detected marked pneumonia, necrotizing type with abscess formation, edema fluid, and fibrinoid material. From the twelve autopsy slides, Dr. Caffrey's final diagnosis was: 1). Necrotizing pneumonia with abscess formation of the left lung; 2). Aspiration type bronchopneumonia right lung; 3). Panlobular and centrilobular emphysema, moderately severe; 4). Minimal amount of anthracotic pigment identified with four subpleural micro-nodules from the right upper lobe of the lung consistent with very minimal CWP; and 5). Two bone marrow emboli from the left upper lobe. Dr. Caffrey considered a coal mine employment history of thirty-one years and a smoking history of forty-six pack years. Dr.

Caffrey, based on his review of the medical records, opined that Miner had a very minimal degree of simple CWP that was diagnosed pathologically and was definitely not evident clinically. He stated that the very minimal degree of simple CWP did not cause Miner's pulmonary disability and did not cause, contribute to, or hasten Miner's death. Dr. Caffrey attributed Miner's pulmonary disability to his forty-six year pack history of smoking because it caused Miner's emphysema and lung cancer. Because Miner terminally showed cachexia with severe malnutrition and the development of methicillin resistant Staphylococcus septicemia leading to his death despite vigorous therapy, Dr. Caffrey opined that Miner would have expired at the same time whether or not he ever worked in the coal mines.

Hospital Records

Dr. Sundaram admitted Miner to Central Baptist Hospital on April 16, 1998 and discharged him on April 19, 1998 after ordering a bronchoscopy and right thoracotomy. Miner underwent a bronchoscopy and right thoracotomy with wedge resection of right upper lobe and biopsy of hilar mass on April 16, 1998 performed by Dr. Saha. Dr. Saha found fibrous plaque with intracosis and material consistent with cilicosis from the biopsy of the wedge resection. Dr. Saha found small cell undifferentiated carcinoma from the hilar mass biopsy.

Miner was examined on November 14, 1999 at Our Lady of the Way Hospital after experiencing shortness of breath and smothering. (DX 34). The admitting impression was COPD exacerbation and bronchitis. He was discharged on November 18, 1999 with a final diagnosis of respiratory failure.

On December 5, 1999, Dr. Sundaram admitted Miner to the Our Lady of the Way Hospital after Miner was brought to the emergency room with a history of shortness of breath, chest congestion, and respiratory distress of progressive nature over the past two weeks. On December 9, 1999, Miner underwent a bronchoscope, brush, and lavage. Dr. Sundaram noted that a chest x-ray showed COPD without change, evidence for previous surgery, picture consistent with COPD and as reviewed by Dr. Sundaram, silicosis and CWP. Dr. Sundaram discharged Miner on December 10, 1999 with diagnoses of purulent bronchopneumonia, retained secretions, COPD with acute exacerbation, ASHD, and panic attacks.

Dr. Sundaram admitted Miner to the Our Lady of the Way Hospital on January 6, 2000 and discharged him on January 9, 2000. Miner was admitted after developing severe anemia following chemotherapy. Dr. Sundaram's discharge diagnosis included severe anemia, status post-chemotherapy, COPD, ASHD, and silicosis.

Miner was hospitalized at Our Lady of the Way Hospital on January 13, 2000 and then discharged on January 14, 2000 under the care of Dr. Sundaram for significant chest congestion and bronchospasm. Dr. Sundaram's discharge diagnosis was acute exacerbation of COPD with bronchitis, status post-chemotherapy for small cell carcinoma of the lung, and panic attacks from history.

Miner was admitted to the Appalachian Regional Hospital on April 25, 2000 due to a sudden onset of shortness of breath and discharged on April 26, 2000 by Pervical Pajel, MD. Miner's diagnoses on discharge were respiratory failure, COPD with advanced emphysema, status post lung carcinoma, and status post colonic carcinoma.

Miner was admitted to Pikeville Methodist Hospital on July 22, 2000 and he was discharged on September 7, 2000. (DX 43). Sixteen final diagnoses were rendered upon Miner's discharge, including respiratory failure, exacerbation of COPD, chronic ventilatory failure secondary to COPD, paroxysmal atrial fibrillation, anemia, colon cancer, rectal bleeding, external hemorrhoids, anorexia, and malnutrition. Miner was admitted due to an exacerbation of COPD. Miner was placed on a ventilator during his stay and then progressively weaned before his discharge. Miner was also intubated. Dr. Musgrave treated Miner with chemotherapy for his cancer. Dr. German Dy DeJoya followed Miner through his hospital course. Miner was transferred to the intensive care unit on September 23, 2000 due to his atrial flutter.

Elena Gabor, M.D. admitted Miner to Appalachian Regional Hospital on September 23, 2000 due to tachycardia and an atrial flutter. (DX 41). Miner had an erythema of his skin at a catheter site. The catheter was removed, and cultures from the tip of the catheter were positive for MRSA. Dr. Gabor considered Miner's atrial flutter to be secondary to sepsis associated with Miner's chronic condition. Dr. Gabor treated Miner's sepsis with medication and then transferred him to a swing bed so his antibiotic treatment could be continued on September 27, 2000. Dr. Gabor's diagnosis on discharge were: 1). Paroxysmal atrial flutter; 2). Methicillin-resistant Staphylococcus aureus sepsis; 3). Perirenal azotemia; 4). Dysphagia; 5). Transient thrombocytopenia; 6). Anemia; 7). Advanced COPD; 8). Chronic respiratory failure; 9). Cachexia; and 10). History of lung and colon cancer.

Dr. Gabor continued to follow Miner, providing antibiotic treatment for Miner's sepsis. (DX 41). A chest x-ray on October 5, 2000 showed a partial clearing of Miner's right perihilar infiltrate. However, Dr. Gabor noted that Miner remained clinically unchanged, very weak, bedridden and in no acute respiratory distress with a large amount of white-yellow tracheal secretions through his tube. Subsequent blood cultures and chest x-rays revealed heavy MRSA and worsening infiltration in Miner's right upper and lower lobes with interval increase in pleural effusion on the right side and the development of a new density in the left upper zone by October 9, 2000. A follow-up CT scan was conducted to rule out a mass, but it was more consistent with pneumonia that was now extending to Miner's left upper lobe. On October 15, 2000, Miner was found to be unresponsive. Code Blue was called, but Miner remained asystolic and expired. Dr. Gabor's diagnoses as of October 15, 2000 were: 1). Cardiorespiratory arrest; 2). Bilateral pneumonia, methicillin resistant Staphylococcus aureus positive; 3). Chronic respiratory failure, status post tracheostomy; 4). Skin wound of left upper chest with positive methicillin-resistant Staphylococcus aureus; 5). Hyponatremia; 6). Transient thrombocytopenia; 7). Prerenal azotemia; 8). Anemia; 9). Paroxysmal atrial flutter; 10). Advanced COPD; 11). Cachexia and malnutrition; 12). Status post percutaneous endoscopic gastrostomy insertion; 13). Colon cancer; and 14). History of lung cancer.

Miner's death certificate was completed and signed by Dr. Gabor on November 1, 2000. (DX 41). Miner's date of death was listed as October 15, 2000. Dr. Gabor listed the immediate

cause of Miner's death as cardiorespiratory arrest, due to bilateral pneumonia methicillin-resistant Staphylococcus aureus, due to advanced COPD, chronic respiratory insufficiency, and cachexia, severe malnutrition. Dr. Gabor listed other significant conditions as colon carcinoma and a history of lung carcinoma. Dr. Gabor did not review the autopsy findings prior to completing the cause of death.

Smoking History

The record contains varying accounts of Miner's smoking histories. However, it is clear that Miner smoked in excess of at least one pack per day for thirty-five to forty-five years.

DISCUSSION AND APPLICABLE LAW

1. DUPLICATE LIVING MINER'S CLAIM

Mr. Burke's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, the following elements:

1. That he suffers from pneumoconiosis;

2. That the pneumoconiosis arose, at least in part, out of coal mine employment;

3. That the claimant is totally disabled; and

4. That the total disability is caused by pneumoconiosis.

See §§ 719.3, 718.202, 718.203, 718.204; *Gee v. W.G. Moore*, 9 B.L.R. 1-4, 1-5 (1986); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-212 (1985). Failure to establish any of these elements precludes entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Duplicate Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). Section 725.309(d) provides that:

> If the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the deputy commissioner determines that there has been a material change in conditions or the later claim is a request for modification and the requirements of § 725.310 are met.

The Benefits Review Board defined "material change in conditions" under § 725.309(d) as occurring when a claimant establishes, by a preponderance of the evidence developed subsequent to the prior denial, at least one of the elements of entitlement previously adjudicated against the claimant. *See Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000). The Board has also held that a material change in conditions may only be based upon an element which was previously denied. *Caudill v. Arch of Kentucky, Inc.*, 22 B.L.R. 1-97 (2000) (en banc on recon.) (where Administrative Law Judge found that claimant did not establish pneumoconiosis and did not specifically address total disability, the issue of total disability may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions). Lay testimony alone is insufficient to establish a material change in conditions. *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999).

This matter arises under the jurisdiction of the Sixth Circuit Court of Appeals.[11] In *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit held that, under *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), it is insufficient for the ALJ to merely analyze the newly submitted evidence to determine whether an element previously adjudicated against the claimant has been established. An administrative law judge must also compare the sum of the newly submitted evidence against the sum of the previously submitted evidence to determine whether the new evidence is substantially more supportive of claimant. *Kirk*, 264 F.3d at 609. However, when comparing the newly submitted evidence against the previously submitted evidence, only a substantial difference in the bodies of evidence is required, not a complete absence of evidence at the earlier time. *Id.* at 610 It is legal error for an administrative law judge not to show that there was a worsening of Claimant's condition on the element selected to show a material change. *Id.* at 609.

Miner's previous claim was denied on the basis that he did not establish the presence of pneumoconiosis. Therefore, I will analyze the medical evidence developed after the Miner's prior denial of benefits by Administrative Law Judge Roketenetz on March 31, 1994. If Miner establishes the presence of pneumoconiosis through evidence that is substantially more supportive than the evidence considered by Administrative Law Judge, Miner's duplicate claim will not be denied on the basis of the prior denial of benefits and I will analyze the entire record *de novo* to determine if Miner is entitled to benefits under the Act.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

[14]Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc). Miner last engaged in coal mine employment in Kentucky.

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The newly submitted record contains nine interpretations of four x-rays. Drs. Reddy and Sundaram found the September 18, 1995 chest x-ray to be positive. There were no interpretations to the contrary. Therefore, I find that the September 18, 1995 x-ray is positive for pneumoconiosis. Dr. Vuskovich interpreted a September 25, 1995 x-ray as negative. Since Dr. Vuskovich rendered the only interpretation, I find the September 25, 1995 x-ray to be negative. Three physicians, two of whom were dually-certified as radiologists and B-readers and one of whom was a B-reader, interpreted the July 7, 1999 film as negative. Based on the three negative interpretations, the qualifications of the readers, and the absence of any positive readings, I find the film dated July 7, 1999 to be negative. Two dually-certified physicians and one B-reader interpreted the November 13, 1999 film as negative. There were no positive readings. Based on the three negative interpretations, the credentials of the readers, and the absence of a positive interpretation, I find that the November 13, 1999 film is negative.

I have determined that three of the four chest x-rays are negative for pneumoconiosis. Overall, seven of the nine interpretations were negative. All seven negative interpretations were rendered from films obtained subsequent to the September 18, 1995 positive film. I find that there is insufficient chest x-ray evidence to establish the presence of pneumoconiosis based on the seven subsequent negative interpretations rendered by physicians who were B-readers and dually-certified physicians. Therefore, I find that the Claimant has not established existence of pneumoconiosis by x-ray evidence under subsection (a)(1) at the time of Miner's death.

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. It may also be based upon autopsy evidence when a miner has died. The newly submitted evidentiary record contains the findings from an April 16, 1998 biopsy as well as the findings from an autopsy. I will review the biopsy findings first.

Dr. Bensema's pathological report on the lung and hilar mass tissue samples obtained on April 16, 1998 comply with the quality standards of § 718.106. She found the presence of small cell undifferentiated carcinoma and fibrous plaque with anthracosis and refractile material compatible with silicates. Dr. Bensema did not expressly diagnose the presence of clinical or legal pneumoconiosis. She set forth microscopic and macroscopic pathological findings. I find that Dr. Bensema's opinion is entitled to probative weight. Dr. Hansberger reviewed the three slides from the 1998 biopsy, and offered an opinion that he agreed with Dr. Bensema's surgical pathology report. He stated that he found no evidence of occupational pneumoconiosis of any variety. Dr. Hansbarger did detect focal deposits of anthracotic pigment, but they were without reactive fibrosis and no coal maculae were detected. His final diagnoses included undifferentiated carcinoma, emphysema, and anthracotic pigment, mild, focal, right lung. At his deposition, Dr. Hansbarger attributed Miner's emphysema to cigarette smoking. Dr. Hansbarger also reviewed additional medical records of Miner. He set forth pathological observations and findings, and his reasoning is supported by adequate data. I find that Dr. Hansbarger's opinion is entitled to probative weight enhanced by his board-certifications in clinical and anatomical pathology. Dr. Branscomb reviewed the surgical pathology report of Dr. Bensema and commented that the presence of pneumoconiosis was not demonstrated because there were no findings of a specific scarring reaction to coal dust. He did not that Dr. Bensema used the word anthracosilicosis, which he stated was a term that is no longer used, adding that it can mean the presence of carbon and silica particles in the lung, or it can include the scarring process of CWP or silicosis. Dr. Branscomb set forth pathological findings and observations, and his reasoning is supported by adequate data. I find that Dr. Branscomb's opinion is entitled to probative weight enhanced by his board-certification in internal medicine.

I find that the April 16, 1998 biopsy does not establish the presence of pneumoconiosis. Although it appears that the precursor for a diagnosis of pneumoconiosis is present and Dr. Hansbarger's comment regarding Dr. Bensema's use of anthracosilicosis presents some ambiguity, the opinions of Drs. Branscomb, Fino, and Hansbarger confirm that the minimum findings were not present to diagnose the existence of pneumoconiosis. Dr. Bensema did not opine that pneumoconiosis existed and there was no other reviewing physician to find the existence of pneumoconiosis.

On December 9, 1999, Dr. Sundaram referred Miner to have a bronchoscope, brush, and lavage. The record does not contain the surgical report from that procedure, nor is there a pathology report regarding the tissue that was removed. However, when Dr. Sundaram discharged Miner from the hospital following the procedure, his discharge diagnoses did not include clinical or legal pneumoconiosis. Since there was no analysis of the removed tissue entered into the record, the December 9, 1999 bronchoscope, brush, and lavage cannot support a finding of pneumoconiosis.

Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). A diagnosis of pneumoconiosis issued by the autopsy prosector is entitled to significant probative value because the pathologist who performs the autopsy sees the entire respiratory system as well as other body systems. *See Fetterman v. Director, OWCP*, 7 B.L.R. 1-688, 1-691 (1985). It is proper to accord greater weight to the opinion of the autopsy prosector over the opinion of reviewing pathologists. *Peskie v. U.S. Steel Corp.*, 8 B.L.R. 1-126 (1985); *Similia v. Bethlehem Mines Corp.*, 7 B.L.R. 1-535 (1984). Additionally, it is reasonable to assign greater weight to physicians who have reviewed the autopsy slides over those physicians who have not. *See Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). The Board has held that anthracosis found in lymph nodes may be sufficient to establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, BRB No. 01-0837 BLA (July 30, 2002) (unpublished).

Dr. Bean conducted an autopsy confined to Miner's lungs in compliance with § 718.106 on November 16, 2000. He concluded that no evidence of CWP was seen. He did not detect the presence of any coal macules. Dr. Bean did note the presence of anthracosis as well as emphysema and pneumonia. Dr. Bean set forth clinical observations and findings, and his reasoning is supported by adequate data. I find that Dr. Bean's opinion is entitled to probative weight.

Dr. Perper was the first pathologist to review Dr. Bean's autopsy report and slides. His opinion complied with the quality standards of § 718.106. From his review of thirteen autopsy slides numbered one through twelve, Dr. Perper diagnosed the presence of pneumonia, emphysema, and CWP in a minimal form with focal micro-nodules and no evidence of silica crystals. Dr. Perper only found micro-nodules characteristic of CWP on one of the twelve slides. He found the CWP to be so minimal that it was understandable that the autopsy prosector did not diagnose CWP. Dr. Perper set forth pathological observations and findings, and his reasoning is supported by adequate data. I find that Dr. Perper's opinion is entitled to probative weight enhanced by his board-certifications in clinical, anatomical, and forensic pathology.

Dr. DeLara also reviewed all twelve slides from Miner's autopsy. His opinion complied with the quality standards of § 718.106. His final diagnoses included simple CWP, pneumonia, and emphysema. Dr. DeLara set forth pathological observations and findings, and his reasoning is supported by adequate data. I find that Dr. DeLara's opinion is entitled to probative weight.

Dr. Naeye reviewed ten autopsy slides and the autopsy report before he issued an opinion that complied with § 718.106. He opined that there is no black pigment associated with fibrosis, focal or centrilobular emphysema, which are the minimum findings of a pathological diagnosis of CWP. Dr. Naeye also detected the presence of pneumonia and emphysema. Dr. Naeye set forth pathological observations and findings, and his reasoning is supported by adequate data. I find that Dr. Naeye's opinion is entitled to probative weight.

Dr. Caffrey reviewed Miner's autopsy report and twelve autopsy slides before he issued an opinion that complies with the quality standards of § 718.106. Dr. Caffrey diagnosed the presence of pneumonia, emphysema, and minimal amount of anthracotic pigment identified with four subpleural micro-nodules from the right upper lobe of the lung consistent with very minimal

CWP. Dr. Caffrey set forth pathological observations and findings, and his reasoning is supported by adequate data. I find that Dr. Caffrey's opinion is entitled to probative weight enhanced by his board-certification in clinical and anatomical pathology.

I find that the autopsy evidence establishes the presence of pneumoconiosis. The opinions of Drs. Perper, DeLara, and Caffrey establish that the minimum requirements necessary to diagnose the presence of pneumoconiosis were evident on the autopsy slides. Dr. Naeye issued a reasoned and documented opinion, but he only reviewed ten slides, which is two less than the other physicians. Dr. Perper explained that the extent of pneumoconiosis is so minimal that it is understandable that Dr. Bean's opined that pneumoconiosis is not present. Drs. Perper and Caffrey hold board-certifications in clinical and anatomical pathology, and Dr. Perper is additionally board-certified in forensic pathology. Despite the fact that Dr. Bean was the autopsy prosector, based on the credentials of Drs. Perper and Caffrey and the quality of the reasoning they employed, I assign greater weight to the opinions of Drs. Perper and Caffrey. The credentials of Drs. DeLara, Bean, and Naeye are not contained in the record. The preponderance of the opinions of pathologists reviewing Miner's autopsy slides, after a comparison of the credentials of the reviewing pathologists, establishes that pneumoconiosis was present at the time of Miner's death. Therefore, I find that the Claimant has established the existence of pneumoconiosis through autopsy evidence under subsection (a)(2).

Claimant has established that Miner suffered from pneumoconiosis at the time of his death through the autopsy evidence. Administrative Law Judge Roketenetz denied Miner's previous application for benefits, determining that Miner had not established the presence of pneumoconiosis. Thus, Claimant has established an element of entitlement previously adjudicated against Miner. However, in order to be entitled to a *de novo* review of the entire record, the newly submitted evidence must be substantially more supportive of the living miner's claim than the previously submitted evidence.

After reviewing the evidence of record when rendering his decision and order in 1994, Administrative Law Judge found that none of the evidence supported a finding of pneumoconiosis. The newly submitted evidence, which covers a period of six years, provides substantially more supportive evidence. Specifically, the opinions of Drs. Perper, DeLara, and Caffrey find the presence of pneumoconiosis based on their review of Miner's autopsy slides. The autopsy evidence establishing the presence of simple CWP is substantially more supportive of a finding of pneumoconiosis than the chest x-ray and narrative opinion evidence considered by Administrative Law Judge Roketenetz in his prior denial of benefits. Over the six year period following Administrative Law Judge Roketenetz's denial and prior to Miner's death, the medical evidence documents the deterioration of Miner's physical condition through increased complaints of dyspnea on exertion, cough, and the dependence on supplemental oxygen. Therefore, I find that Claimant has established a material change in condition under § 725.309. The living miner claim shall not be denied on the basis of the prior denial. Rather, the entire record must be reviewed *de novo* to determine Claimant's entitlement to benefits on the living miner claim.

De Novo Review of Living Miner's Claim

Pneumoconiosis

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The entire record contains fifty-five interpretations of fifteen chest x-rays. The first film was obtained on September 2, 1988. Four physicians, who were not radiologists or B-readers, interpreted the film as positive. One physician dually-certified as a radiologist and a B-reader found the film to be unreadable, while three dually-certified physicians found the film to be negative. Another physician, who was not a radiologist or a B-reader, found the film to be negative. I attribute greater weight to the three negative interpretations rendered by dually-certified physicians based on their credentials. Therefore, I find that the September 2, 1988 film is negative.

The next x-ray was taken on October 3, 1988. Of the six interpretations, there were no positive readings. Therefore, I find that the October 3, 1988 film is negative. Two physicians not certified as radiologists or B-readers interpreted a film dated November 3, 1988. One physician detected the presence of COPD, while another found the film to be positive. Based on the positive reading and the absence of contrary probative evidence, I find that the November 3, 1988 x-ray is positive for pneumoconiosis. Dr. Dahhan, a B-reader, rendered the only interpretation of a film dated December 3, 1988. Based on his credentials and his negative interpretation, I find that the film dated December 3, 1988 is negative. The next film was obtained on December 16, 1988. Three dually-certified physicians interpreted the film as negative. Based on the absence of a positive reading and the credentials of the physicians, I find that the December 16, 1988 film is negative. Five physicians rendered interpretations from a film dated March 9, 1989, four of whom were dually-certified physicians. All five interpretations were negative. Therefore, I find that the March 9, 1989 film is negative. The next film was obtained four days later on March 13, 1989. Three dually-certified physicians found the film to be negative. There were no other interpretations. Based on the credentials of the physicians and the absence of a positive interpretation, I find that the March 13, 1989 film is negative. Two dually-certified physicians and three B-readers interpreted the film dated March 22, 1989 as negative. There were no positive readings. Based on the credentials of the reviewing physicians and the absence of any positive readings, I find that the film dated March 22, 1989 is negative.

Miner next submitted to a chest x-ray on January 7, 1992. Drs. Nash and Ramakrishnan, who are not radiologists or B-readers, found the film to be positive. To the contrary, four physicians who were dually-certified, found the film to be negative. I accord greater weight to the more numerous negative interpretations rendered by better qualified physicians. Thus, I find that the January 7, 1992 film is negative. Two B-readers interpreted a chest x-ray obtained on February 19, 1992 as negative. There were no other interpretations. Based on the credentials of the physicians and the lack of a positive interpretation, I find that the February 19, 1992 film is negative.

More than one-and-one-half years later, a board-certified radiologist and Dr. Sundaram interpreted a December 7, 1993 x-ray as positive for pneumoconiosis. There were no contrary negative interpretations. Based on two positive interpretations, one of which was rendered by a board-certified radiologist, and the absence of contrary evidence, I find that the December 7, 1993 film is positive. The next film was obtained almost two years later on September 18, 1995. Dr. Sundaram and Dr. Reddy, who is a B-reader, both interpreted the film as positive. There were no contrary negative interpretations. Based on the two positive interpretations, including one by a B-reader, and the absence of any negative interpretations, I find that the September 18, 1995 film is positive. Dr. Vuskovich, a B-reader, interpreted a film dated September 26, 1995 as negative. There were no other interpretations. Therefore, I find that the September 26, 1995 film is negative. Two dually-certified physicians and a B-reader interpreted the film dated July 7, 1999 as negative. There were no positive readings. Therefore, I find the film dated July 7, 1999 to be negative. The final film was obtained on November 13, 1999. Two dually-certified physicians found the film to be negative. There were no positive readings. Therefore, I find that the November 13, 1999 film is negative.

I have determined that twelve of the fifteen chest x-rays were negative. Of the fifty-five interpretations that were rendered, only twelve were positive. Nine of the positive interpretations were rendered by physicians who were not board-certified radiologists or B-readers, which included four positive interpretations by Dr. Sundaram. Of the forty-three negative interpretations, twenty-seven were issued by dually-certified physicians. The two most recent x-rays were determined to be negative based on six negative interpretations and no positive interpretations. I find that a preponderance of the chest x-ray evidence is negative for the existence of pneumoconiosis based on an overwhelming majority of negative interpretations rendered by B-readers and dually-certified physicians. Therefore, I find that Claimant has not established the presence of pneumoconiosis at the time of Miner's death under subsection (a)(4).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. It may also be based upon autopsy evidence when a miner has died. Miner underwent a biopsy on September 23, 1988. Stewart Wolfson, M.D. reviewed bronchial washings, lavage, and brushings from both lungs. Dr. Wolfson noted that the tissue samples were negative for malignant cells. He did not render any pathological findings or observations consistent with a diagnosis of pneumoconiosis. I previously determined that the 1998 biopsy did not support a finding of pneumoconiosis. However, I have previously determined, after reviewing all autopsy evidence contained in the entire record, that Claimant has established the presence of pneumoconiosis at the time of Miner's death through autopsy evidence. Therefore, I find that Claimant has established the existence of pneumoconiosis at the time of Miner's death through autopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Sundaram first opined that Miner suffered from CWP in 1988. He examined Miner on August 16, 1988, January 19, 1989, and February 16, 1989. Over that time period, he reviewed a chest x-ray, PFTs, and ABGs. He considered an accurate account of Miner's smoking and coal mine employment histories. He also submitted Miner to a stress test. Dr. Sundaram diagnosed CWP based on his review of chest x-rays. The Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). The Board has also explained that, when a doctor relies solely on a chest x-ray and coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc.*, 8 B.L.R. 1-405 (1985). *See also Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989)(it is permissible to discredit the opinion of a physician which amounts to no more than a restatement of the x-ray reading). Despite the objective and subjective evidence at his disposal, Dr. Sundaram's stated bases for his diagnosis of CWP were chest x-rays and history of coal dust exposure. Thus, for the period of 1989 through 1993, Dr. Sundaram did not render a reasoned and documented medical opinion finding the presence of clinical pneumoconiosis. However, during the same time period and based on the PFTs and ABGs he conducted, Dr. Sundaram diagnosed a moderate pulmonary impairment arising out of Miner's exposure to coal dust. This opinion is reasoned and documented because Dr. Sundaram set forth clinical observations and findings, and his reasoning was supported by adequate data. However, in comparison to other medical opinions in the

record, Dr. Sundaram offered only minimal reasoning and did not attempt to reconcile the effects of Miner's smoking history on the etiology of Miner's COPD.

Following an October 1988 examination, Dr. Mettu opined that Miner suffered from a mild pulmonary impairment due to smoking. He submitted Miner to a chest x-ray, PFT, and an ABG. He considered an accurate account of Miner's smoking and coal mine employment history. He set forth clinical observations and findings, and his reasoning was supported by adequate data. His opinion is reasoned and documented. I find that Dr. Mettu's 1988 opinion is entitled to probative weight in an amount that is limited by the remoteness in time of his opinion to Miner's death.

Dr. Vanhoose examined Miner in December 1988 and diagnosed the presence of CWP based on his x-ray interpretation. He also submitted Miner to a PFT, from which he concluded that Miner suffered from a moderate pulmonary impairment related to airways disease. Dr. Vanhoose's diagnosis of clinical pneumoconiosis was based solely on his chest x-ray interpretation and knowledge of Miner's coal mine employment history. For the purposes of this subsection, Dr. Vanhoose's diagnosis of clinical pneumoconiosis does not constitute a reasoned medical opinion. Furthermore, since he attributed Miner's pulmonary impairment to airways disease, and not coal dust exposure, it does not amount to a diagnosis of legal pneumoconiosis. Dr. Wright examined Miner on the same day as Dr. Vanhoose and he rendered a similar opinion, finding the presence of pneumoconiosis by chest x-ray. Thus, Dr. Wright's opinion cannot constitute a reasoned medical opinion under this subsection. From the PFT he conducted, he diagnosed a moderate obstructive impairment contributed to by airways disease and likely caused by cigarette smoking. Dr. Wright's set forth clinical observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Miner's smoking and coal mine employment histories. Despite diagnosing CWP, he attributed Miner's pulmonary impairment to smoking. His opinion is reasoned and documented. I find that Dr. Wright's opinion is entitled to probative weight in an amount relative to the remoteness in time of his opinion to Miner's death.

Dr. Vuskovich examined Miner in March of 1989. He considered an accurate account of Miner's smoking and coal mine employment histories. From a chest x-ray he diagnosed emphysema. He found a PFT to reveal a moderate impairment, while he noted an ABG to be normal. He diagnosed pulmonary emphysema due to smoking and a moderate impairment reversed to a mild impairment after bronchodilators were given. Dr. Vuskovich's diagnosis of emphysema was primarily based on his chest x-ray interpretation. His medical conclusions do not support a finding of clinical or legal pneumoconiosis.

Miner was also examined by Dr. Anderson in 1989, who is a board-certified pulmonologist. He interpreted a chest x-ray as negative, and conducted a PFT and ABG. He considered an accurate account of Miner's smoking and coal mine employment histories. He diagnosed pulmonary emphysema with airflow obstruction. He concluded that Miner had no CWP based on his chest x-ray. Thus, Dr. Anderson's diagnosis of the absence of CWP cannot constitute a reasoned medical opinion for the purposes of this subsection. His diagnosis of pulmonary emphysema with airflow obstruction is a reasoned and documented opinion, which contradicts a finding of legal pneumoconiosis. He set forth clinical observations and findings,

and he relied upon adequate data to support his diagnosis. Therefore, I find that Dr. Anderson's diagnosis contradicting the presence of legal pneumoconiosis is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist in an amount relative to the remoteness in time of his opinion from Miner's death.

Dr. Broudy, who is also a board-certified pulmonologist, issued a consultative opinion after reviewing Miner's medical records in October 1989. He concluded that Miner did not suffer from CWP based on the preponderance of the evidence. He diagnosed COPD due to smoking. Dr. Broudy set forth clinical observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Broudy's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist in an amount relative to the remoteness in time of his opinion to Miner's death.

Dr. Lane also conducted a consultative review of Miner's medical records in October 1989. He found that a preponderance of the evidence plus the B-reader x-ray interpretations showed no CWP. He concluded in his report and subsequent deposition that Miner suffered from a mild to moderate pulmonary impairment due to smoking. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Lane's opinion is entitled to probative weight.

Dr. Branscomb was the third physician to conduct a consultative review of Miner's medical records in October 1989. He found no evidence of a restrictive disease. Rather, he noted that Miner suffered from a mild obstructive impairment that shows reversibility after the administration of bronchodilators, which is diagnostic of chronic bronchitis or asthma from cigarette smoking and is totally opposite to the findings that would lead to the diagnosis of CWP. Dr. Branscomb set forth clinical observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Branscomb's opinion is entitled to probative weight enhanced by his board-certification in internal medicine in an amount relative to the remoteness in time of his opinion to Miner's death.

The record shows that Miner was next examined by Dr. Nash in January 1992. He diagnosed chronic bronchitis, COPD, and CWP 1/1. He opined that Miner's pulmonary problems were mostly due to his coal dust exposure because Miner did not ever have pulmonary infections, he didn't have tuberculosis, and he only had pneumonia occasionally. Dr. Nash was subsequently presented with evidence contradicting his opinion. In a subsequent opinion in 1992, after reviewing the contradictory evidence, Dr. Nash stated that it did not change his opinion. Dr. Nash's diagnosis of clinical pneumoconiosis appears to be based solely on his chest x-ray interpretation, which cannot constitute a reasoned medical opinion under this subsection. However, he also diagnosed legal pneumoconiosis. Dr. Nash set forth clinical observations and findings, and his reasoning diagnosis legal pneumoconiosis is supported by adequate data. He considered an accurate account of Miner's coal mine employment history and a slightly depressed account of Miner's smoking history. However, I find that Dr. Nash's opinion was diagnosing legal pneumoconiosis was reasoned and documented, partly based on his defense of his opinion after being presented with contradictory evidence. I find that Dr. Nash's diagnosis of

legal pneumoconiosis is entitled to probative weight in an amount relative to the remoteness in time of his opinion from Miner's death.

Dr. Broudy examined Miner in 1992. He interpreted a chest x-ray as negative and conducted a PFT and ABG. He found the PFT to reveal a moderate to severe impairment, and noted that the ABG showed mild to moderate hypoxemia. He diagnosed moderate to severe COPD due to smoking. He also diagnosed chronic bronchitis and emphysema due to smoking. Dr. Broudy reviewed additional medical records, and submitted a supplemental opinion in October 1993 finding that his opinion from 1992 had not changed. Dr. Broudy set forth clinical observations and findings, and his reasoning is supported by adequate data. He again considered an accurate account of Miners' smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Broudy's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist in an amount relative to the remoteness in time of his opinion to Miner's death.

Drs. Branscomb and Lane also submitted consultative reports in October 1993 after reviewing Miner's medical records. They both found that Miner did not suffer from CWP. They diagnosed a moderate obstructive abnormality related to COPD that was caused by cigarette smoking. They set forth clinical observations and findings, and their reasoning is supported by adequate data. Their opinions are reasoned and documented. I find that Dr. Branscomb's opinion is entitled to probative weight enhanced by his board-certification in internal medicine in an amount relative to the remoteness in time of his opinion to Miner's death. I find that Dr. Lane's opinion is entitled to probative weight in an amount relative to the remoteness in time of his opinion to Miner's death.

Dr. Sundaram examined Miner in December of 1993 and September of 1995. Both times he diagnosed the presence of clinical pneumoconiosis based on his chest x-ray interpretations. Those opinions cannot constitute a reasoned medical opinion under this subsection. Dr. Vuskovich examined Miner in September 1995. He found that there was no objective evidence of pneumoconiosis, nor any evidence of any occupational lung disease. He found that Miner suffered from a severe obstructive impairment secondary to emphysema, which he attributed to Miner's smoking history. Dr. Vuskovich considered an accurate account of Miner's smoking and coal mine employment histories. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Vuskovich's opinion is entitled to probative weight in an amount relative to the remoteness in time of his opinion to Miner's death.

Dr. Sundaram examined Miner again in 1998. He noted that a chest x-ray showed moderately advanced emphysema and a lobulated mass in the right front hilum. He recommended that Miner undergo a biopsy. He examined Miner a year later in October 1999. He diagnosed CWP on the basis of a prolonged history of coal dust exposure. Dr. Sundaram's diagnosis of clinical pneumoconiosis cannot constitute a reasoned medical opinion for the purposes of this subsection since it is based solely on coal dust exposure history and possible a chest x-ray interpretation. He also found that Miner suffered from a totally disabling pulmonary impairment that is one-hundred percent attributable to Miner's CWP, which constitutes a diagnosis of legal pneumoconiosis. He noted that Miner had stopped smoking. Dr. Sundaram

set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion diagnosing legal pneumoconiosis is reasoned and documented. I find that Dr. Sundaram's diagnosis of legal pneumoconiosis is entitled to probative weight. At his deposition in March 2000, Dr. Sundaram noted that he had been treating Miner since 1989. However, he could not recall or locate in his files the chest x-ray interpretation he relied upon to diagnose CWP in his October 1999 report. He also could not recall an accurate account of Miner's smoking or coal dust exposure histories. He admitted that smoking could have played a role in Miner's pulmonary impairment, but he also stated that Miner could have had a reversibility of the damage caused by his cigarette smoking since he stopped smoking.

Dr. Wicker examined Miner in July 1999 and opined that Miner suffered from a pulmonary impairment due to his history of cigarette abuse and known partial resection of his lung. He found no evidence of pneumoconiosis. Dr. Wicker set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Wicker's opinion is entitled to probative weight.

Dr. Dahhan examined Miner in November 1999 and issued a report. He concluded that Miner had emphysema resulting from Miner's forty-six pack years of smoking and cancer of the right lung that was post-resection with chemo and radiation therapy. He found no objective evidence of CWP or any occupationally acquired lung disease. Dr. Dahhan set forth clinical observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Dahhan's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist. Dr. Dahhan confirmed his opinion through a consultative opinion rendered after reviewing additional medial records of Miner in June 2000. He reviewed the findings from Miner's 1998 biopsy. In his consultative report, Dr. Dahhan found that Miner did not suffer from CWP when his coal dust exposure ended in 1988. He attributed Miner's present pulmonary impairments to Miner's cancer and its treatment. He found that Miner's pulmonary impairment also arose from emphysema which arose out of Miner's smoking habit. In support of this finding, he noted that Miner's emphysema showed a response to bronchodilator therapy, which is a finding inconsistent with the permanent adverse effects of coal dust on the respiratory system. Dr. Dahhan's supplemental consultative opinion is also reasoned and documented and entitled to probative weight. Dr. Dahhan issued a supplemental opinion in September 2001 after reviewing additional medical records, including the 1998 pathology report and the autopsy reports. He concluded that there was insufficient evidence to diagnose the presence of CWP, noting that the gold standard for pathologically diagnosing CWP (based on Drs. Hansbarger and Bensema) was not found. He attributed Miner's centrilobular emphysema to Miner's many years of cigarette smoking. Dr. Dahhan issued another supplemental consultative report in March 2003. After reviewing additional records, Dr. Dahhan concluded that Miner suffered from minimal, simple CW based on the majority of pathologists who evaluated Miner's pathological evidence. Dr. Dahhan set forth clinical observations and findings, and his reasoning is supported by adequate data. His supplemental opinions are entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Branscomb issued a supplemental consultative opinion in July 2000 after reviewing Miner's medical records. He reviewed the pathological findings from Miner's 1998 biopsy. He also reviewed Dr. Sundaram's deposition testimony, noting that Dr. Sundaram's observation that Miner's pulmonary symptoms wax and wane to be consistent with a diagnosis of asthma or asthmatic bronchitis and inconsistent with CWP. He also found Miner's pulmonary impairment to be non-occupational in nature because of the evidence of reversibility after the administration of a bronchodilator. Dr. Branscomb concluded that there is no evidence that Miner suffers from CWP or any other occupationally acquired pulmonary disease. Dr. Branscomb set forth clinical observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Branscomb's opinion is entitled to probative weight enhanced by his board-certification in internal medicine.

Dr. Fino also issued a consultative opinion in July 2000. He found that the chest x-rays, PFT, lung biopsy, and evidence that demonstrates Miner's pulmonary impairment is caused by his history of smoking supports a conclusion that Miner does not suffer from an occupationally acquired pulmonary disease. Dr. Fino set forth clinical observations and findings, and his reasoning is supported by adequate data and medical literature. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Fino's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist. Dr. Fino also provided deposition testimony and issued a supplemental consultative opinion in May 2001. In his supplemental opinion, Dr. Fino concluded that he found no evidence of CWP at the time of Miner's death. His supplemental opinion was also reasoned and documented. It was based on his clinical observations and findings from reviewing Miner's medical records. There was adequate data to support his reasoning. Dr. Fino issued another supplemental opinion in March 2003. This time, he reviewed the pathological evidence generated from Miner's autopsy. He stated that he agreed with the opinions of Drs. Perper and Caffrey that Miner suffered from simple CWP at the time of his death. Dr. Fino also reviewed the surgical pathology report of Dr. Bensema. In his July 19, 2000 opinion he stated that the lung biopsy showed evidence of coal mine dust deposition in the lungs called anthracosis, but it did not show CWP because there was no description of coal macules surrounded by fibrosis and emphysema. Dr. Fino set forth pathological observations and findings, and his reasoning is supported by adequate data. I find that Dr. Fino's opinion is entitled probative weight enhanced by his credentials as a board-certified pulmonologist.

In July 2000, Dr. Musgrave, who was treating Miner for his small cell carcinoma concluded that Miner suffered from an occupational lung disease arising out of coal mine employment. Her opinion was based on a PFT and chest x-ray. She attributed Miner's pulmonary impairment to his CWP because Miner's cancer was in remission. Dr. Musgrave did not set forth sufficient clinical observations and findings because she failed to identify what specific tests she relied upon. She supplemented her July 2000 opinion with a brief narrative opinion in October 2001. She noted that she treated Miner from 1998 until his death and added that Miner's carcinoma was in remission at the time of his death. She opined that Miner's death was due to his chronic black lung disease, but she did not provide any additional rationale to support her diagnosis of pneumoconiosis. Overall, her opinions are conclusory and lack

sufficient rationale to constitute a reasoned medical opinion under this subsection. Therefore, I find that Dr. Musgrave's opinion is entitled to a lesser degree of probative weight.

Dr. Sundaram issued a report in December 2000, wherein he stated that he reviewed the autopsy report. He concluded that the finding of "athracic [sic] pigment distributed in fibrous tissue" confirms and substantiates his reasoned medical opinion that Miner suffered from CWP. In addition to Dr. Sundaram's narrative reports, the record contains summaries completed by Dr. Sundaram upon discharging Miner from various hospitalizations. In December 1999, Dr. Sundaram treated Miner for an exacerbation of COPD, ordered a bronchoscope, brush, and lavage. He interpreted an x-ray as positive for COPD, silicosis, and CWP. However, CWP was not listed as a diagnosis on discharge. Dr. Sundaram listed silicosis as a diagnosis upon discharging Miner in January 2000 following his treatment of Miner for anemia related to chemotherapy. He did not diagnose CWP upon treating Miner for an exacerbation of COPD in January 2000. In June 2001, after Miner had died, Dr. Sundaram completed an examination report, on which he gave his opinion that Miner had a chronic pulmonary impairment or black lung that was caused by Miner's twenty-nine year history of coal mine employment. He noted that Miner's small cell carcinoma could also be a possible cause of Miner's impairment, but he stated that Miner only developed carcinoma late in life. Dr. Sundaram reiterated these findings in his July 2001 deposition. He testified that the basis for his June 2001 opinion were his interpretation and review of chest x-rays dating back to 1988, his clinical examinations, and the autopsy report. At the deposition Dr. Sundaram was only able to state that Miner had quit smoking quite many years ago and that he worked several years as a Miner. Based on his deposition testimony, I find that Dr. Sundaram's June 2001 opinion is reasoned and documented. Even though he was unable to testify to an accurate account of Miner's smoking and coal mine employment histories, his reports dating back to 1988 contained an accurate account of Miner's smoking and coal mine employment histories. Dr. Sundaram relied on these accounts when offering his opinion in June 2001. Dr. Sundaram completed a treating physician form in June 2002. He found that Miner suffered from an occupational lung disease based on Miner's prolonged exposure to coal dust. He stated that his diagnosis of pneumoconiosis was based on his treatment of Miner, not solely on his chest x-ray interpretations. He also opined that Miner's pulmonary impairment was caused by his coal dust exposure and cigarette smoking. I find that Dr. Sundaram's opinions and deposition testimony are collectively entitled to probative weight. After analyzing the full scope of the opinion evidence rendered by Dr. Sundaram, it is evident that his diagnosis of clinical and legal pneumoconiosis were based on his clinical observations and findings, as well as objective medical evidence, Miner's subjective complaints, and his review of Miner's autopsy results. What remains is the amount of weight to attribute to Dr. Sundaram's opinions based on his status as Miner's treating physician from 1988 through Miner's death.

The amended regulations at § 718.104(d) (2002) are not directly applicable because this evidence was developed prior to January 19, 2001, but it is instructive. *See Wolf Creek Collieries v. Director, OWCP [Stephens]*, 298 F.3d 511 (6th Cir. 2002). An administrative law judge may rely upon the well-reasoned and well-documented opinion of a treating physician as substantial evidence in awarding that physician's opinion controlling weight based upon four factors: (1) nature of relationship; (2) duration of relationship; (3) frequency of treatment; and (4) extent of treatment. § 718.104(d) (2002). Dr. Sundaram's opinion is entitled to probative

weight. However, his opinion does not demonstrate that he gained unique and substantial probative evidence regarding Miner's condition based on his status as Miner's treating physician. Despite his lengthy treatment history of Miner, which included following and attending to Miner when Miner was hospitalized due to exacerbations of COPD and in relation to the treatment of his small cell carcinoma, Dr. Sundaram's reports, testimony, and supporting rationale did not demonstrate that the nature and extent of his treatment of Miner warranted additional weight. The physicians who reviewed Miner's clinical and pathological evidence were on similar footing with Dr. Sundaram when it came to determining the status of Miner's pulmonary condition. The other physicians of record identified the requisite criteria for diagnosing pneumoconiosis and provided better rationale to support their opinions. While Dr. Sundaram's opinions collectively establish a reasoned and documented narrative opinion, they are not of sufficient quality to warrant additional weight solely upon his status as Miner's treating physician. Therefore, I find that the collective opinions of Dr. Sundaram finding that Miner suffered from pneumoconiosis are entitled to probative weight.

Dr. Broudy also issued a supplemental consultative opinion in March 2003. After reviewing additional medical records, including the pathology evidence and reports, he opined that the evidence suggests that Miner suffered from the presence of microscopic evidence of minimal, simple CWP at the time of his death. Dr. Broudy set forth clinical observations and findings, and his reasoning is supported by adequate data. I find that Dr. Broudy's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Drs. DeJoya and Gabor treated Miner over the last four months of Miner's life. Their opinions support a diagnosis of COPD, but not a finding of legal pneumoconiosis because they never provide an opinion as to the etiology of Miner's COPD.

I find, after considering all of the narrative medical opinions, that Claimant has established the presence of pneumoconiosis at the time of Miner's death. Prior to 2003, Dr. Sundaram was the only physician of record to find that Miner suffered from pneumoconiosis. To the contrary, numerous physicians found that there was insufficient objective medical evidence from which to diagnose clinical pneumoconiosis. These physicians also found that Miner suffered from a pulmonary impairment, but attributed it to Miner's lengthy smoking history, chronic bronchitis, and asthma. Dr. Bean performed an autopsy on Miner's lungs and issued a report in November 2000. After reviewing the autopsy evidence and in some instances the reports of other pathologists who reviewed the autopsy slides, Drs. Broudy, Dahhan, and Fino all reversed their previous opinions and diagnosed the presence of clinical pneumoconiosis at the time of Miner's death based on their review of the autopsy evidence and the pathologists' reports. These three physicians had previously rendered numerous opinions finding that there was no evidence to support the finding of pneumoconiosis. In addition to these three physicians, Dr. Sundaram diagnosed the presence of clinical and legal pneumoconiosis. Dr. Branscomb concluded that Miner did not suffer from pneumoconiosis in July 2000, but he was not privy to the results of the autopsy report. Therefore, I find the opinions of Drs. Dahhan, Fino, Broudy, and Sundaram, all of whom reviewed the autopsy report, to be more probative than the other narrative opinions of record, especially the opinions that were remote in time to Miner's death. Pneumoconiosis is defined as a latent and progressive disease, therefore I accord greater probative weight to the more recent evidence. § 718.201(c). While the preponderance of

evidence from 1988 through 2000 failed to establish the presence of pneumoconiosis, the evidence rendered after the autopsy was performed clearly finds the presence of pneumoconiosis. I find that Claimant has established the presence of pneumoconiosis at the time of Miner's death by a preponderance of the evidence under subsection (a)(4).

Claimant has established the presence of pneumoconiosis at the time of Miner's death through autopsy and narrative opinion evidence. Therefore, I find that Claimant has established the presence of pneumoconiosis.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that Claimant has established that Miner engaged in twenty-nine years of coal mine employment, and as no rebuttal evidence was presented, I find that Miner's pneumoconiosis arose out of his coal mine employment in accordance with the rebuttable presumption set forth in § 718.203(b).

Total Disability

To prevail, Claimant must also demonstrate that Miner was totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both "like" and "unlike" must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I find that Claimant has not established that Miner suffered from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Several physicians, including Dr. Branscomb found that the record does not contain a valid pulmonary functions tests. Dr. Sundaram even noted that Miner had a difficult time providing good effort due to his condition. The record does not contain a pulmonary function test that substantially complies with the quality standards set forth at § 718.103 and Appendix B to Part 718. Therefore, I find that Claimant has not established that Miner was totally disabled at the time of his death under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) by the results of arterial blood gas studies. The tests conducted on July 7, 1999, and November 13, 1999 achieved qualifying results. The next most recent test was performed in 1995, which did not produce a

qualifying result. I accord greater weight to the more recent evidence because it is more probative of Miner's condition at the time of his death. Based on the two qualifying tests, I find that Claimant established total disability by a preponderance of the arterial blood gas study evidence under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence of cor pulmonale with right-sided congestive heart failure to consider. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment consisted of general underground work, which included roof bolting, cleaning beltlines, and rock dusting.

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

The evidence from 1988 through the time of Miner's death demonstrated a progressively worsening pulmonary impairment that developed into a severe obstructive impairment and severe hypoxemia by 1999. In 2000, Miner was diagnosed as suffering from severe emphysema, chronic bronchitis, COPD, and possibly asthma. Miner had already had already been diagnosed with small cell undifferentiated lung carcinoma and had part of his right upper lung lobe resectioned in 1998. Drs. Dahhan, Fino, Branscomb, and Broudy determined that Miner suffered from severe pulmonary impairments which prevented him from being able to perform his usual coal mine employment or comparable gainful work. Their opinions were based on their review of Miner's pulmonary function tests, arterial blood gas studies, and the findings from clinical examinations. Miner's usual coal mine employment involved arduous manual labor. He was seventy-one years old at the time of his death and he had a third grade education. The evidence overwhelmingly establishes that Miner's severe pulmonary impairment and severe hypoxemia prevented him from being able to engage in his usual coal mine employment at the time of his death. Therefore, I find that Claimant has established by a preponderance of the evidence that Miner was totally disabled at the time of his death under subsection (b)(2)(iv).

I have determined that Claimant has established total disability through arterial blood gas study evidence and narrative opinion evidence. Miner's pulmonary function tests values were indicative of total disability, but they did not comply with the applicable quality standards of § 718.103. After considering all of the evidence regarding the level of Miner's pulmonary functioning, I find that Claimant has established that Miner was totally disabled due to a pulmonary impairment at the time of his death. Both of the ABGs conducted in 1999 produced qualifying values. Additionally, all of the physician who reviewed Miner's medical records in the year or two prior to his death determined that Miner was unable to perform his usual coal mine employment due to his severe pulmonary impairment. Therefore, I find that Claimant has established that Miner was totally disabled due to a pulmonary impairment at the time of his death.

Total Disability Due to Pneumoconiosis

To be entitled to benefits, after establishing the presence of pneumoconiosis arising out of coal mine employment and the existence of a totally disabling pulmonary impairment, Claimant must establish that Miner's total disability was due to pneumoconiosis arising out of coal mine employment. The amended regulations at § 718.204(c) contain the standard for determining whether Miner's total disability was caused by Miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith*, 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due 'at least in part' to his pneumoconiosis. *Cf.* 20 C.F.R. 718.203(a)." *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's "impairment is due to his combined dust exposure, coal workers' pneumoconiosis as well as his cigarette smoking history" is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk}*, 264 F.3d 602 (6th Cir.

2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

The reasoned medical opinions of those physicians who diagnosed the existence of pneumoconiosis and that Miner was totally disabled are more reliable for assessing the etiology of Miner's total disability. *See, e.g. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

Drs. Sundaram, Broudy, Dahhan, Fino, Perper, and Caffrey rendered opinions after Miner died finding the presence of a totally disabling pulmonary impairment and the presence of pneumoconiosis. Thus, I find the opinions of these six physicians to be the most probative opinions for determining whether Miner's totally disabling pulmonary impairment was due to his pneumoconiosis arising out of coal mine employment. I will also consider the opinion of Drs. Naeye, who did not find the presence of pneumoconiosis.

Dr. Sundaram completed an examining physician form in June 2001 and then provided deposition testimony regarding his report. He answered yes to the question of whether Miner had a pulmonary impairment and/or black lung that was caused by his twenty-nine years of coal mine employment. He allowed that Miner's small cell carcinoma could also be a possible etiology of Miner's pulmonary impairment, but he noted that developed the carcinoma only at a very late point in life. In a June 2002 report, Dr. Sundaram stated that Miner's COPD and exacerbation were significantly aggravated by his CWP. He also answered that Miner's chronic lung disease was a condition causally related to Miner's inhalation of coal mine dust. He stated that it was difficult to separate the impairment caused by coal mine employment from the impairment caused by cigarette smoking. Although he had a difficult time recalling an accurate account of Miner's smoking and coal mine employment histories, Dr. Sundaram relied on records that contained accurate accounts. Dr. Sundaram's opinions were based on the 1998 biopsy report, autopsy report, his clinical examinations, and x-ray interpretations. He set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is minimally reasoned and documented. I find that Dr. Sundaram's opinion is entitled to probative weight. As I previously determined, the collective body of Dr. Sundaram's opinions does not demonstrate that he possessed unique and substantive evidence regarding Miner's condition based on his status as Miner's treating physician from 1988 until Miner's death in 2000, the information he relied upon and the quality of reasoning Dr. Sundaram employed does not warrant attributing additional probative weight to his opinion due to his status as Miner's treating physician.

Dr. Perper issued a consultative opinion in February 2001 after reviewing Miner's medical records and autopsy slides. He found the presence of simple pneumoconiosis and found that Miner suffered from a totally disabling pulmonary impairment. However, he opined that at the time of Miner's death, Miner was clearly not totally disabled due to a respiratory impairment arising out of coal dust exposure because Miner's CWP was so minimal and sparse that it could not have resulted in a pulmonary disability. Rather, Dr. Perper attributed Miner's total disability to chronic COPD, pulmonary emphysema, and status post-resection of lung cancer, all of which resulted from Miner's thirty-five to forty-five years of heavy smoking. Dr. Perper found Miner's emphysema to have been caused by cigarette smoking, not coal dust, because Miner's CWP was

not severe enough and Miner didn't have silicosis. Dr. Perper set forth clinical and pathological observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Perper's opinion is entitled to probative weight enhanced by his credentials as a board-certified anatomical, surgical, and forensic pathologist.

Dr. Naeye, in a September 2002 opinion found that Miner did not suffer from pneumoconiosis, but he did find that Miner suffered from a totally disabling pulmonary impairment. Dr. Naeye opined, that since the minimum findings for a diagnosis of simple CWP are absent, then there is no basis to postulate that Miner's CWP caused his disability. Dr. Naeye's opinion is predicated on the absence of simple CWP. He did not render an opinion on the etiology of Miner's total disability assuming that Miner had simple CWP. Since the predicate of Dr. Naeye's opinion is not supported by the evidence of record and conflicts with the undersigned's finding that simple pneumoconiosis was present at the time of Miner's death, I find that Dr. Naeye's opinion is entitled to a lesser degree of probative weight.

Dr. Musgrave found that Miner was a respiratory cripple in July 2000, noting that Miner was totally dependent upon supplemental oxygen. She offered an opinion in October 2001 finding that Miner's death was due to pneumoconiosis. However, the record does not contain a reasoned medical opinion from Dr. Musgrave attributing Miner's totally disabling pulmonary impairment to pneumoconiosis.

In February 2003, Dr. Caffrey issued a consultative opinion finding the presence of pneumoconiosis and concluding that Miner suffered from a totally disabling pulmonary impairment after reviewing Miner's medical records and autopsy slides. Since the pneumoconiosis he detected was so minimal, Dr. Caffrey found that it did not cause Miner's pulmonary disability. Instead, he found that Miner's pulmonary disability was caused by Miner's smoking history because it caused Miner's emphysema and lung cancer. Dr. Caffrey set forth clinical and pathological observations and findings, and his reasoning is supported by adequate data. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Caffrey's opinion is entitled to probative weight enhanced by Dr. Caffrey's credentials as a board-certified clinical and anatomical pathologist.

Dr. Broudy diagnosed the presence of simple CWP and found that Miner did not retain the respiratory capacity to perform his usual coal mine employment in his March 2003 opinion rendered after reviewing Miner's medical records and the pathology evidence from Miner's autopsy. However, Dr. Broudy attributed Miner's inability to perform his usual coal mine employment to Miner's COPD arising out of cigarette smoking. He found no evidence of any pulmonary impairment arising out of Miner's coal mine dust inhalation. He found that Miner's CWP was not clinically evidence and was so minimal that it had no affect on miner's pulmonary function. Dr. Broudy set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Broudy's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Also in March 2003 opinion, Dr. Dahhan found that Miner suffered from a very minimum simple CWP. He found that the amount of CWP found by the autopsy evidence was too minimal to cause any respiratory impairment. Dr. Dahhan set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Dahhan's March 2003 opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

Dr. Fino was the third physician to offer a consultative opinion in March 2003, in which he found the presence of pneumoconiosis. However, Dr. Fino did not render an opinion in March 2003 on the cause of Miner's pulmonary impairment at the time of Miner's death. Dr. Fino previously rendered an opinion in July 2000 finding that Miner was totally disabled due to a pulmonary impairment caused by smoking. Even though he opined that there was insufficient evidence to diagnose pneumoconiosis, Dr. Fino, assuming that Miner suffered from legal pneumoconiosis, found that Miner would have still been totally disabled after repairing whatever small level of disability that would have been caused by legal pneumoconiosis. Dr. Fino set forth clinical observations and findings, and his reasoning is supported by adequate data. He cited to medical literature to support his opinion on the etiology of Miner's pulmonary impairment. He considered an accurate account of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. However, the probative effect of Dr. Fino's July 2000 opinion is limited because, even though he opines that Miner would have been totally disabled by the impairments caused by his smoking alone, it does not preclude a finding that Miner's pneumoconiosis was a substantially a substantially contributing cause.

Drs. Wicker, Dahhan, Branscomb, and Fino, who rendered opinions prior to Miner's death and the subsequent autopsy finding of simple pneumoconiosis, found that Miner's totally disabling respiratory impairment was caused by Miner's smoking habit because Miner's smoking habit led to the development of Miner's emphysema and his small cell carcinoma that resulted in partial lung resection.

I accord greater weight to the opinions of Drs. Broudy, Caffrey, Dahhan, and Perper on the basis of their credentials and the superior reasoning they employed when offering an opinion on the etiology of Miner's totally disabling respiratory impairment in comparison to the opinion of Dr. Sundaram. Drs. Broudy, Caffrey, Dahhan, and Perper relied upon the autopsy findings showing only a minimal degree of simple pneumoconiosis. They relied on those findings to conclude that Miner's total disability could not have been caused by CWP because it was too minimal to cause an impairment. They attributed Miner's pulmonary impairment to the conditions caused by Miner's lengthy smoking habit. Prior to the pathological diagnosis of pneumoconiosis, all physicians except for Dr. Sundaram attributed Miner's pulmonary impairment to the conditions caused by Miner's smoking history. The evidence establishes that Miner's simple CWP was to minimal to have been more than an infinitesimal or *de minimus* cause of Miner's total disability; Miner's simple CWP was not a substantially contributing cause of his total disability. I find that Miner's totally disabling pulmonary impairment was due to conditions caused by Miner's smoking history, including the partial lung resection arising out of the treatment of Miner's lung cancer, as well as emphysema and COPD. Claimant has failed to establish by a preponderance of the evidence that Miner's totally disabling pulmonary impairment was due to Miner's pneumoconiosis arising out of coal mine employment.

Since Claimant has failed to establish that Miner's totally disabling respiratory impairment was due to Miner's pneumoconiosis arising out of coal mine employment, the living miner claim must be denied.

2. SURVIVOR'S CLAIM

Mrs. Burke filed her survivor's claim on November 17, 2000. Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, the claimant must prove that:

1). The miner had pneumoconiosis;

2). The miner's pneumoconiosis arose out of coal mine employment; and

3). The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Death Due to Pneumoconiosis

Mrs. Burke has established, by a preponderance of the autopsy and narrative opinion evidence, that Miner suffered from pneumoconiosis arising out of coal mine employment. She must now prove that Miner's death was due to pneumoconiosis in order to be entitled to benefits. Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that an eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that pneumoconiosis was the cause of the Miner's death, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

20 C.F.R. § 718.205(c).

Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5). The presumption set forth in § 718.304 is not applicable because Claimant has not established the presence of complicated pneumoconiosis. Therefore,

in order for Claimant to be entitled to benefits, she must show that pneumoconiosis was the direct cause of Miner's death or that pneumoconiosis hastened Miner's death.

A death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*. 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988).

Dr. Gabor, who treated Miner over the last few months of his life while he was hospitalized, signed Miner's death certificate. Dr. Gabor listed that immediate cause of Miner's death as cardiorespiratory arrest, due to bilateral pneumonia, due to advanced COPD, chronic respiratory insufficiency, and cachexia, severe malnutrition, with other significant conditions of lung and colon carcinoma listed. Based on the hospital records, I find that Dr. Gabor possessed relevant knowledge of Miner's condition from which to assess the cause of death. Thus, I find that death certificate is entitled to probative weight.

Dr. Gabor treated Miner in September and October of 2000 and she completed a discharge diagnosis after Miner died on October 15, 2000, which summarized the course of Miner's treatment and provided final diagnoses. Dr. Gabor never rendered a diagnosis of legal or clinical pneumoconiosis, nor did she note the existence of legal or clinical pneumoconiosis as part of Miner's medical history. Dr. Gabor's records show that Miner developed MRSA at the site of a catheter by September 23, 2000, for which she instituted antibiotic treatment. She noted that Miner's sepsis was creating an atrial flutter. Dr. Gabor interpreted an October 5, 2000 chest x-ray as showing heavy MRSA and worsening pneumonia. Miner's condition was noted to be very weak, bedridden, but in no acute respiratory distress.

Dr. Perper conducted a microscopic review of Miner's autopsy slides and rendered a consultative opinion based on his review of the autopsy slides and additional medical evidence in February 2001. He found the presence of minimal simple CWP. However, he concluded that Miner's death was not significantly contributed to or hastened by pneumoconiosis. Rather, Dr. Perper found that Miner's respiratory conditions and related complications were secondary to Miner's heavy smoking history. Dr. Perper found that Miner's smoking habit resulted in chronic COPD, pulmonary emphysema, and status post-resection of his right lung. Even though it is known that significant CWP and silicosis can be associated with the development of centrilobular emphysema, Miner had less than an insignificant degree of pneumoconiosis and no silicosis. Dr. Perper concluded by opining that Miner's death was caused by severe chronic lung disease and related complications, which were non-occupational in nature and were the result of Miner's long-standing and heavy smoking of tobacco. Dr. Perper set forth clinical and pathological observations and findings, and his reasoning is supported by adequate data. He considered accurate accounts of Miner's smoking and coal mine employment histories. His opinion is reasoned and documented. I find that Dr. Perper's opinion is entitled to probative weight enhanced by his credentials as a board-certified anatomical, surgical, and forensic pathologist.

In May of 2001, before he changed his opinion and diagnosed the presence of simple CWP, Dr. Fino opined that Miner's death was due to cardiorespiratory arrest due to severe cachexia, wasting away. Dr. Fino attributed Miner's cachexia to Miner's lung carcinoma. He found that Miner would have died as and when he did had Miner never engaged in coal mine employment. Thus, he opined that Miner's death was not related to coal mine dust inhalation. Dr. Fino, after reviewing the pathology reports and diagnosing simple CWP, issued a consultative opinion in March 2003 wherein he stated that he agrees with the opinions of Drs. Perper and Caffrey that simple CWP did not cause, contribute, or hasten Miner's death. Dr. Fino's March 2003 supplemental opinion did not set forth any clinical observations or findings. In fact, his entire report was eleven lines in length. Dr. Fino's March 2003 report does not constitute a reasoned medical opinion. While he identifies the evidence he relied upon, he provides no rationale to support his conclusion, which prevents an analysis of the reliability of his conclusion. Dr. Fino's May 2001 report was issued before Dr. Fino diagnosed simple CWP based on the autopsy results, and he did not render an opinion on the cause of death assuming that simple pneumoconiosis was found. Since Dr. Fino changed his opinion on the presence of simple CWP after he issued his May 2001 report and failed thereafter to offer a reasoned medical opinion on the cause of Miner's death, I attribute less probative weight to the opinions of Dr. Fino on the cause of Miner's death.

Dr. DeLara reviewed Miner's autopsy slides and issued a consultative opinion in June 2001. He found that presence of simple CWP. Dr. DeLara opined that the cause of Miner's death was severe organizing bronchopneumonia and also aspiration pneumonia. Dr. DeLara set forth pathological observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. DeLara's opinion is entitled to probative weight.

In June 2001, Dr. Sundaram completed an examining physician report on which he answered yes to the question of whether Miner's lung condition caused, contributed to, or hastened Miner's death. In support of his answer, Dr. Sundaram directed the reader of his opinion to refer to the 1998 biopsy, the autopsy report, and his treatment records, but he did not provide any specific rationale. During his July 2001 deposition, Dr. Sundaram stated that basis for his June 2001 answer was that Miner's comprised lung status due to silicosis was detrimental on top of Miner's cancer. Dr. Sundaram completed another treating physician form in July 2002, on which he again answered yes to the question of whether pneumoconiosis caused, contributed to, or hastened Miner's death. Dr. Sundaram's stated rationale was "please see enclosed." Dr. Sundaram also noted that he had prescribed supplemental oxygen for Miner due to Miner's low oxygen levels. However, the way that Dr. Sundaram's July 2002 was contained in the record, there were no supporting documents attached. Dr. Sundaram's opinion constitutes a minimally reasoned and documented opinion based on his deposition testimony in conjunction with the forms he completed and his references to additional medical records that he relied upon to reach his conclusion. Therefore, I find that Dr. Sundaram's opinion that Miner's death was caused by, contributed to, or hastened by pneumoconiosis is entitled to probative weight.

In September 2001, after reviewing Miner's hospital records and the 1998 biopsy report, but before he changed his opinion to find the presence of pneumoconiosis, Dr. Dahhan issued a consultative opinion finding that Miner had centrilobular emphysema caused by cigarette

smoking, but he did not render an opinion on the cause of Miner's death. By March 2003, Dr. Dahhan had diagnosed the presence of simple pneumoconiosis after reviewing autopsy evidence. However, he stated that the amount of CWP noted to be present by the reviewing pathologists was too minimal to cause any respiratory impairment or to contribute to Miner's death. Instead, Dr. Dahhan found that Miner died from small cell lung cancer and its complications, noting that one-year survival after a patient is diagnosed with small cell lung cancer is extremely low. He concluded that Miner's simple CWP did not contribute to or hasten Miner's death. Dr. Dahhan's March 2003 report is minimally reasoned and documented. He set forth the evidence he reviewed, and then rendered conclusions based on that evidence. Dr. Dahhan provided a small amount of supporting rationale. Thus, I find Dr. Dahhan's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

In a brief narrative opinion rendered in October 2001, Dr. Musgrave, who was treating Miner at the time of his death for colon cancer, stated that Miner's lung cancer was in remission at the time of his death with no evidence of the disease at the time of Miner's death. She attributed Miner's death to problems related to his chronic black lung disease with respiratory insufficiency. Dr. Musgrave did not consider note any account of Miner's smoking and coal mine employment history. She did not refer to any objective testing nor to any clinical or pathological evidence. Dr. Musgrave's ultimate opinion does not constitute a reasoned medical opinion for the purposes of determining whether Miner's death was due to pneumoconiosis. However, since she was treating Miner at the time of his death for colon cancer, I credit her statement that Miner's lung cancer was in remission at the time of his death.

In September 2002, Dr. Naeye reviewed Miner's medical records and the autopsy slides. He concluded that there was insufficient pathological evidence to diagnose the presence of pneumoconiosis. Since he determined that the minimum findings for the diagnosis of CWP were absent, Dr. Naeye found no basis for postulating that CWP caused, contributed to, or hastened Miner's death. Dr. Naeye set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Naeye's opinion is entitled to probative weight enhanced by his credentials as a board-certified clinical and anatomical pathologist.

Dr. Caffrey reviewed Miner's medical records and the autopsy slides before he issued a narrative report in February 2003. He found that Miner suffered from a very minimal amount of CWP that was diagnosed pathologically and was definitely not evidence clinically. Dr. Caffrey opined that Miner's minimal simple CWP did not cause, contribute to, or hasten Miner's death. Dr. Caffrey found that Miner would have died at the same time whether or not he ever worked in the coal mines because Miner terminally showed cachexia with severe malnutrition and the development of MRSA leading to his death despite vigorous therapy. Dr. Caffrey set forth clinical and pathological observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Caffrey's opinion is entitled to probative weight enhanced by his credentials as a board-certified clinical and anatomical pathologist.

Dr. Broudy, in March 2003, issued a consultative opinion finding that Miner suffered from minimal simple pneumoconiosis based on his review of the pathology evidence. However, he found that the microscopic pneumoconiosis was not able to be clinically diagnosed before Miner's death and had no affect on Miner's death. Rather, Dr. Broudy found that Miner died due to complications of small cell lung cancer, which is considered all but incurable. He concluded that there is no evidence that Miner's death was caused or hastened by the inhalation of coal mine dust. Dr. Broudy set forth clinical observations and findings, and his reasoning is supported by adequate data. His opinion is reasoned and documented. I find that Dr. Broudy's opinion is entitled to probative weight enhanced by his credentials as a board-certified pulmonologist.

The evidence establishes that Miner's death occurred as the result of cardiorespiratory arrest brought about by COPD, pneumonia caused by MRSA, and emphysema. The conditions that caused Miner's cardiorespiratory arrest were caused by Miner's lengthy and heavy smoking history and by a bacterial infection. Even though Dr. Musgrave stated that Miner's small cell carcinoma was in remission, which is somewhat contradicted by the other physicians comments finding small cell carcinoma to be a highly fatal disease that is virtually incurable, the opinions of the physicians who found that Miner's pulmonary problems were complicated by his small cell carcinoma are reliable. Miner had part of his right lung resectioned and underwent radiation and chemotherapy treatment. At the time of Miner's death he was also receiving adjuvant therapy for colon cancer. Miner's treatment resulted in cachexia and severe malnutrition, which Dr. Fino termed as wasting away. The evidence overwhelmingly shows that Miner's simple degree of pneumoconiosis was to insignificant cause, contribute to, or hasten Miner's death. The opinions of Drs. Broudy, Dahhan, DeLara, Caffrey, Fino, and Perper contradict and undermine the opinions of Drs. Sundaram and Musgrave. Dr. Sundaram's opinion, while reasoned and documented, employed very little reasoning to reach his conclusion and offered little insight into his opinion on the extent of Miner's pneumoconiosis. Dr. Musgrave, who did not assess the extent of Miner's pneumoconiosis, also offered little supporting rationale. In contrast, the physicians who reviewed Miner's autopsy slides (Drs. DeLara, Caffrey, and Perper) found Miner's simple CWP to be too minimal to have caused, contributed to, or hastened Miner's death. On this point, I find that the opinions of Drs. DeLara, Caffrey, and Perper to be better reasoned since they provided a clear opinion on the extent of Miner's simple CWP and used it to support their opinion on the cause of Miner's death. Drs. Broudy, Dahhan, and Fino applied the same reasoning. Dr. Gabor, who treated Miner over the last month of his life and who signed Miner's death certificate, did not offer an opinion that Miner's death was caused by, contributed to, or hastened by pneumoconiosis; Dr. Gabor did not even diagnose the presence of pneumoconiosis or note a history of pneumoconiosis. Dr. Naeye found that Miner's death was not due to pneumoconiosis, but I find the opinions of those physicians who found the presence of pneumoconiosis to be more probative on the issue of whether Miner's death was due to pneumoconiosis. I find that Miner's death was not caused, contributed to, or hastened by Miner's minimal degree of simple pneumoconiosis. Therefore, I find that Claimant has failed to establish that Miner's death was due to pneumoconiosis arising out of coal mine employment. Accordingly, Claimant's application for survivor benefits must be denied.

Entitlement

The Claimant, Gwendolyn Sue Burke, has failed to prove by a preponderance of the evidence, that Miner's totally disabling pulmonary impairment was due to his pneumoconiosis arising out of coal mine employment. Claimant has also failed to prove by a preponderance of the evidence that Miner's death was due to pneumoconiosis arising out of coal mine employment. Therefore, Mrs. Burke is not entitled to living miner or survivor benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim Clarence Burke's claim for living miner benefits and Gwendolyn Sue Burke's claim for survivor benefits under the Act are hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**